STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435009	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/11/25 through 3/13/25. Avantara Milbank was found not in compliance with the following requirements: F623, F625, F675, and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/11/25 through 3/13/25. The areas surveyed were resident safety related to the use and supervision of mechanical and non-mechanical lifts to transfer residents. Avantara Milbank was found not in compliance with the following requirement: F689.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623	1. Past failures to provide proper notification regarding residents 2,9, and 186 cannot be remedied. All residents have the potential to be impacted by lack of proper notifications. 2. Administrator or designee will conduct education to Social Services Designee and nurses on the Discharge and Transfer of Residents/Bed Hold Policy on or before 4/21/25. Those associates not in attendance at the education will be educated prior to their first worked shift. 3. The Administrator or designee will audit weekly x4 weeks and monthly for 2 months on all transfers that require notification to the ombudsman to ensure proper notification and policies are followed. Results of the audit will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	4/21/2025

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

[signature] | Administrator | 4/03/25

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.

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F 623	Continued From page 1 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 2 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to notify or provide a copy of the transfer notice to the Office of the State	F 623		

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F 623	Continued From page 3 Long-Term Care Ombudsman for three of three sampled residents (2, 9, and 186) who were hospitalized after admission to the facility. Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed: *She admitted to the facility on 4/17/24. *She was admitted to the hospital on 5/23/24 and returned to the facility on 5/28/24. *There was no documentation that indicated the ombudsman was notified of that transfer. 2. Review of resident 9's EMR revealed: *She admitted to the facility on 4/1/24. *She was transferred to the hospital and admitted on 10/9/24. *There was no documentation that indicated the ombudsman was notified of that transfer. 3. Review of resident186's EMR revealed: *She admitted to the facility on 1/13/25. *She was admitted to the hospital on 2/19/25. *There was no documentation that indicated the ombudsman was notified of that transfer. 4. Interview on 3/13/25 at 8:36 a.m. with administrator A regarding providing notice to the ombudsman of resident transfers to the hospital revealed: *She expected the business office manager to have completed the notification to the ombudsman of resident 9's transfer to the hospital. -That business office manager no longer worked at the facility. *There was no documentation that indicated the ombudsman had been notified of resident 9's transfer to the hospital.	F 623		

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F 623	Continued From page 4 *There had been recent staffing changes, and she now expected the social services designee to provide the notification to the ombudsman when a resident transferred to the hospital. 5. Interview on 3/13/25 at 10:48 a.m. with assistant administrator C revealed there was no documentation that indicated the ombudsman had been notified of resident 2 or resident 186's transfers to the hospital. 6. Interview with the facility's local ombudsman by email on 3/13/25 at 1:06 p.m. regarding notification of resident transfers to the hospital revealed she had not received notifications of resident 2, 9, or 186's above hospital transfers. 7. Review of the document shared by the Ombudsman revealed: *"Notice before transfer. *Before a facility transfers or discharges a resident, the facility must - (i) *Notify the resident and the resident representative(s) of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. *That facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman."	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625	1. Past failures to provide bed hold information to residents 2,9, and 186 cannot be remedied, though they were all allowed to return to their previous rooms upon being readmitted. All residents have the potential to be impacted by not receiving the bed hold notice when transferring.	4/21/2025

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F 625	Continued From page 5 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to provide bed-hold notices to the resident or the resident's responsible party at the time of transfer to a hospital for three of three sampled residents (2, 9, and 186) who were hospitalized after admitting to the facility. Findings include: 1. Interview on 3/11/25 at 12:24 p.m. with resident 9 revealed she: *Had been hospitalized since she was admitted to the facility but did not remember why. *Did not recall having been given a bed hold notice but was allowed to return to the facility after that hospital admission.	F 625	2. Administrator or designee will conduct education to the Social Services Designee and nurses on the Discharge and Transfer of Residents/Bed Hold Policy on or before 4/21/25. Those associates not in attendance at the education session will be educated prior to their first worked shift. 3. The administrator or designee will audit weekly x4 weeks and monthly for 2 months on bed holds to ensure proper notification and policies are followed. Results of audits will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 625	Continued From page 6 2. Review of resident 9's electronic medical record (EMR) revealed: *She admitted to the facility on 4/1/24. *She was transferred and admitted to the hospital on 10/9/24. -Her power of attorney (POA) was notified of that transfer. -There was no documentation that indicated the bed hold information was given to the resident or her POA. 3. Interview on 3/11/25 at 12:35 p.m. with resident 186 revealed she: *Had been hospitalized recently but could not recall the date of that hospitalization. *Did not recall having been given a bed hold notice but was allowed to return to the facility after that hospital admission. 4. Review of resident186's EMR revealed: *She admitted to the facility on 1/13/25. *She was admitted to the hospital on 2/19/25 after a clinic appointment. *She was her own responsible party. *There was no documentation that indicated the bed hold information was given to the resident. 5. Review of resident 2's EMR revealed: *She admitted to the facility on 4/17/24. *She had been hospitalized on 5/23/24 and returned to the facility on 5/28/24. *She was her own responsible party. *There was no documentation that indicated the bed hold information was given to the resident. 6. Interview on 3/12/25 at 4:25 p.m. with licensed practical nurse (LPN) I regarding bed hold notices revealed:	F 625		

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*If a resident went to the hospital the nurse would have notified the POA of that hospitalization and documented that notification in the EMR progress note.
*The social worker was responsible for completing and providing the bed hold notices.

7. Interview on 3/13/25 at 8:36 a.m. with administrator A regarding bed hold notices revealed:
*She expected the business office manager would have provided the bed hold to resident 9 when she was admitted to the hospital after her clinic appointment because she was her own responsible party.
-That business office manager no longer worked at the facility.
*The bed hold notice for resident 9 had not been provided for the above hospitalization.
*There had been recent staffing changes, and she now expected the social services designee to provide the bed hold notices when a resident transferred to the hospital.

8. Interview on 3/13/25 at 10:48 a.m. with assistant administrator C revealed bed hold notices were not provided to resident 186 or resident 2 for the above hospitalizations.

9. Review of the provider's undated Bed Reserve Policy Notification revealed:
*"This Bed Reserve Policy will be given to you at the time of admission and a copy will be given to you each time you are transferred from the facility."
*"Under normal circumstances, if you leave the facility for a hospitalization, you will be readmitted to the first available bed in a semi-private room. Under certain conditions, we can reserve your

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F 625	Continued From page 8 existing bed for you at your request, so when you return to the facility, you will have the same bed and room as before." *My signature below acknowledges that I have been provided with a copy of the South Dakota Bed Hold Policy."	F 625		
F 675 SS=E	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, resident council review, and policy review, the provider failed to ensure prompt response to call lights and necessary care and services were provided for six of six residents (5, 8, 9, 15, 23, and 285) and one of six additional resident council meeting residents (18) to maintain their physical, mental, and emotional well-being. Those residents expressed frustration related to the delay in staff response to their call lights and requests for assistance. Findings include: 1. Observation and interview on 3/11/25 at 12:25 p.m. with resident 5 in her room regarding call light response times revealed: *Sometimes it would have taken staff an hour to answer her call light and it had frustrated her.	F 675	1. Call light function being troubleshooted for all residents, including residents 5,8,9,15,23, and 285. All residents had the potential to be impacted. Virtual meeting conducted with Arial technicians on 3/25. Arial changed the content of the messages on the pagers to help with clarity on the time the call light was pressed. On 3/25, Arial technicians had staff walk throughout the facility to ascertain if there were any issues with pagers receiving messages. Staff noted three instances where pages failed to be received by the pagers or where the text on the pagers was incorrect. Pages were still being received properly at the kiosks. Arial scheduled for a technician to come to the facility and do a coverage test. Technician arrived on 3/31 and conducted a coverage test. He changed the way the call lights were assigned to help reduce signal interference. Technician scheduled to return on 4/09/2025 to install a high gain antenna to boost signal throughout building. The facility has ordered 3 kiosks to increase visibility of call lights in all occupied wings.	4/21/2025

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F 675	Continued From page 9 *Resident 5's daughter stated she had witnessed 30-45 minutes. 2. Interview on 3/11/25 at 1:00 p.m. with resident 285 revealed: *Staff would take a long time to answer call lights, especially around meal times. *Sometimes it would take staff 20 to 30 minutes for staff to answer her call light. *She felt they were short on staff who could help residents sometimes. 3. Interview on 3/11/25 at 1:05 p.m. with resident 8 revealed she felt staff took a long time to answer her call light. 4. Interview on 3/11/25 at 3:19 p.m. with resident 15 revealed: *He said staff wanted him to use his call light for assistance. -When he used it, he felt it took them a long time to answer it. -He has fallen in the past. -This was frustrating to him. *He stated he had witnessed CNAs gathered at the nurses' station ignoring call lights. 5. Interview on 3/12/25 at 2:30 with resident 23 revealed: *Call light response wait times were very long, sometimes as long as one hour. *Resident 23 said, "When I have to go to the bathroom, I don't have an hour [to wait for help]." -This was frustrating to the resident. 6. Interview on 3/12/25 at 10:40 a.m. with licensed practical nurse (LPN) I revealed: *The facility had a new call light system, less than	F 675	2. Administrator or designee will conduct education to all staff regarding their roles and responsibilities related to ensuring the residents' quality of life, meeting the residents' care needs, and the expectations for staff to respond to call lights and then following through on the residents' requests and call light policy on or before 4/21/25. Those associates not in attendance at the education session will be educated prior to their first worked shift. 3. Administrator or designee will audit weekly x4 weeks and monthly for 2 months on call lights response time. Results of audits will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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six months old.
-There was a central monitor at the nurse's station that showed activated call lights until they were answered.
*All caregiver staff (such as certified nursing assistants (CNAs) and nurses) carried a pager to notify them when a call light was activated.
*The pager would remind them of an activated call light at five-minute intervals until the call light was answered.
*The facilities' proccess was nurses usually would not answer call lights until after the first five minutes had passed.
*She expected staff to answer residents' call lights within ten minutes.

7. Interview on 3/12/25 at 11:20 a.m. with registered nurse (RN) G revealed:
*She did not feel staff time for answering call lights was an issue.
*She expected staff to answer residents' call lights within five to ten minutes.
*She felt a wait longer than 15 minutes was unacceptable.

8. Interview on 3/12/25 at 11:30 with CNA E revealed:
*The provider's expectation to answer call lights was five minutes.
*That was regularly reminded to staff during daily huddles (a team meeting daily to give staff updates).

9. Review of call light logs for resident 285 revealed:
*She had pressed her call light 44 times between 2/10/25 and 3/1/25.
*Eight times the response time was over ten minutes.

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F 675	Continued From page 11 *Four times the response time was over 20 minutes. *Four times the response time was over 30 minutes. 10. Review of call light logs for resident 9 revealed: *She had pressed her call light 178 times between 2/10/25 and 3/1/25. *Thirty-five times the response time was over ten minutes. *Ten times the response time was over 20 minutes. *Six times the response time was over 30 minutes. *Three times the response time was over 40 minutes. 11. Review of call light logs for resident 23 revealed: *She had pressed her call light 236 times between 2/10/25 and 3/1/25. *Fourty-four times the response time was over ten minutes. *Twenty-two times the response time was over 20 minutes. *Three times the response time was over 30 minutes. *Seven times the response time was over 40 minutes. *One time the response time was over 50 minutes. *One time the response time was over 90 minutes. 12. Review of call light log for resident 8 revealed: *She had pressed her call light 28 times between 2/10/25 and 3/1/25. *6 times the response time was over ten minutes.	F 675		

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F 675	Continued From page 12 *1 time the response time was over 20 minutes. *3 times the response time was over 30 minutes. *2 times the response time was over 40 minutes. *1 time the response time was over 60 minutes. 13. Review of call light logs for resident 5 revealed: *She had pressed her call light six times between 2/10/25 and 3/1/25. *Three times the response time was over ten minutes. *One time the response time was over 20 minutes. 14. Review of the provider's 2/25/25 resident council (a meeting where residents can discuss concerns with staff) minutes revealed: *Three of the six residents in attendance shared the concern that their call lights were not being answered timely. -Specifically, during morning hours, medication passes, and at bedtime. *Call light audits from 2/28/25 revealed: -One call light was answered in seven minutes. -Six call lights were answered in less than five minutes. 15. Review of provider's 2/7/25, 2/10/25, and 2/11/25 "Daily Shift Huddle" sheet revealed: *"Expectation for call light is to respond within 5 minutes." 16. Review of the provider's 3/3/25 daily shift huddle sheet revealed: *"2. Call bells [call lights] concern-remember to answer promptly." 17. Interview on 3/12/25 at 12:20 p.m. with interim director of nursing (IDON) B revealed:	F 675		

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	435009	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 675	Continued From page 13 *She expected staff to answer residents' call lights as soon as possible, and stated within five to ten minutes was reasonable. *She said taking longer than 15 to 20 minutes to answer call lights was unacceptable. 18. Review of the provider's 9/30/24 call lights policy revealed: *"Policy-It is the policy of the facility to ensure that there is prompt response to the resident's call for assistance." *Procedures "1. Facility shall answer call light in a timely manner. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that staff member will be back to assist them shortly."	F 675		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, record review, interview, observation, manufacturer's manual review, and policy review, the provider failed to ensure resident safety by improper use of lift equipment as directed in the residents' care plans and/or the lift manufacturer's manual for: *One of two sampled resident (9) who required	F 689	1. No Immediate correction could be completed for residents 9 and 14. Interventions were put in place to prevent recurrence for these two residents as well as to prevent further falls for all residents who utilize lifts. 2. Administrator or designee will conduct education for all nursing staff on the Care Plan policy and manufacturer guidelines on lifts on or before 4/21/25. Those associates not in attendance at the education session will be educated prior to their first worked shift. Lift competencies will continue to be required to be completed for all new hires in the nursing department or new agency personnel in the nursing department prior to them working without supervision.	4/21/2025

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F 689	Continued From page 14 the assistance of two staff for transfers with a lift, who was lowered to the floor while being transferred with the use of a mechanical sit-to-stand lift (a mechanical lift that requires the person to partially bear weight on at least one leg when assisted from a seated position to a standing position) by one certified nursing assistant (CNA) (K) without the assistance of another qualified staff person. *One of two sampled resident (14) who required the assistance of two staff for transfers with a lift, who was lowered to the floor while being transferred with the use of a non-mechanical (manual) sit-to-stand lift by CNA (M) without the assistance of another qualified staff person. 1. Review of the provider's 1/28/25 SD DOH FRI regarding resident 9 revealed: *On 1/28/25 at 4:00 p.m. while certified nursing assistant (CNA) K was attempting to transfer resident 9 to the commode with the sit-to-stand lift she "assisted" her to the floor when the "right side of the sling came off the lift." *CNA K did not follow manufacturer guidelines when securing the sling to the lift. *Resident 9 was evaluated by the nursing staff and had no injury. *Resident 9's physician and power of attorney (POA) were notified. *CNA K was suspended and reinstated after she was provided education and demonstrated competency with proper sling use and securement. *The resident's care plan was "reviewed and noted to have appropriate interventions in place." 2. Review of resident 9's electronic medical record (EMR) revealed: *Her diagnoses included acquired absence of	F 689	3. Administrator or designee will audit 3 random transfers via lifts weekly x4 weeks and monthly for 2 months to ensure all steps of the lift process are followed per manufacturer guidelines and policies. Results of audits will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QPI) meeting for continuation/ discontinuation/revision of audits based on audit findings.	

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F 689	Continued From page 15 right leg above the knee, morbid obesity, and Epilepsy. *Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *The care plan indicated: -"Stand lift for transfers unless [resident 9] is uncomfortable with the CNA and wants the Hoyer lift [a mechanical lift and sling used to lift a person's full body] used." -She required the assistance of two staff when she was "feeling weak or tired when transferring in [the] stand lift." -"Allow [resident 9] to choose what stand lift to use when transferring." -Resident 9 had a right lower leg prosthesis. "Do not don [put on] before using [the] mechanical lift. Refusing use at present time." *A 1/28/25 incident progress note indicated, "CNA called [the] nurse to [the] resident room for an assisted fall ...[The] right strap became separated from [the] lift suggestive of sling placement misalignment ... pain medication given for stump [residual limb] pain." 3. Observation and interview on 3/12/25 at 1:46 p.m. with resident 9 regarding the 1/28/25 incident involving the mechanical sit-to-stand lift revealed: *She had an above-the-knee amputation of her right leg and did not wear a prosthesis. *She stated the lift sling came unattached from the right side of the lift when CNA K raised the lift from a sitting position to a standing position. *She fell to the floor and bumped her right leg. *She had two medium size sit-to-stand lift slings hanging from her bedroom door. *The CNAs were trained on a "new way" to hook the sit-to-stand lift sling strap so that it did not	F 689		

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F 689	Continued From page 16	F 689		

come unhooked.
-She always checked now that the lift sling was attached correctly.

4. Observation and interview on 3/13/25 at 9:38 a.m. with CNA H and resident 9 revealed:
*She received education and had to demonstrate how to use the mechanical sit-to-stand lift and attach the sling correctly to transfer a resident "three to four times in a row" about a month ago.
*She knew how to transfer resident 9 because it was on her care plan.
*She transferred resident 9 from the commode to her wheelchair and applied the sling correctly.

5. Interview on 3/13/25 at 8:35 a.m. and again at 9:04 p.m. with administrator A regarding the incident with resident 9 on 1/28/25 revealed:
*CNA K had not correctly attached the sling to the mechanical sit-to-stand lift, and resident 9 was lowered to the floor when that sling came unhooked from the lift.
*Education on how to attach the mechanical sit-to-stand lift sling was completed on 1/28/25.
-Staff competencies (demonstration of proper technique) on the sit-to-stand lifts had been started after the incident on 1/28/25.
*She expected staff to use the lift slings per the manufacturer's guidelines.
*No audits had been completed for the correct use of the slings and lifts since that incident.

6. Interview on 3/13/25 at 11:03 a.m. with human resources coordinator L revealed that CNA K no longer worked at the facility and was unavailable for interview.

7. Review of the provider's 1/28/25 "How to apply [the] sling for [the] sit-to-stand lift correctly" staff

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F 689	Continued From page 17 education revealed: *The education sheet contained three pictures of how to attach the lift sling. *There were nine steps listed for the process of "Transferring to a Commode Chair" with the mechanical sit-to stand-lift. *Handwritten information was added, "Sling should be pulled around the outside of the bar and hooked that way." 8. Review of the (Name) manufacturer's undated mechanical sit-to-stand manual revealed: *"Ensure the following ...the loops of the sling are completely on the hooks of the lift arms." -There was a reference to a picture labeled "Sling Attachment." 9. Review of the provider's 2/24/25 SD DOH FRI regarding resident 14 revealed: *On 2/22/25, CNA M was using a nonmechanical sit-to-stand lift to transfer resident 14. *While in the nonmechanical sit-to-stand lift, resident 14 sat down prematurely. -He was safely lowered to the floor and was unharmed. *Resident 14 was to have "cares in pairs" (the assistance of two staff when providing residents' care) due to his cognitive impairment. *CNA M was suspended until she had completed the education on cares in pairs. 10. Review of resident 14's electronic medical record (EMR) revealed: *He had a BIMS assessment score of 3, which indicated he was severely cognitively impaired. *His diagnoses included Alzheimer's Dementia, anxiety, congestive heart failure, and chronic kidney disease. *His care plan indicated: -A focus area of "I require assistance with ADLs	F 689		

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F 689	Continued From page 18	F 689		

[activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting)."
-A goal of "I will be assisted with ADL's as needed.
-Interventions of "Provide Cares in Pairs. All cares should be done with 2 care givers [caregivers] present."
-"Date initiated: 01/17/25."

11. Phone interview on 3/13/25 at 10:55 a.m. with CNA M revealed:
*She had been a CNA for about eight months.
*She was not aware resident 14 was to have two staff assisting during all resident care.
*She reported the resident was standing on the nonmechanical sit-to-stand lift, and he started to sit down before the lift's padded seat could be positioned into place.

12. Interview on 3/13/25 at 11:30 a.m. with CNA E revealed:
*The facility had two types of lifts; mechanical and non-mechanical.
*All lifts should have been operated with two staff members and never operated with just one staff.

13. Review of the provider's 9/30/24 "Care Plans" policy revealed:
*"Policy: Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: 1. Each resident is an individual. The personal history, habits, like and dislikes, life pattens and routines, and personality facets must be addressed in addition to medical/diagnosis-based care

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F 689	Continued From page 19 considerations." *"The Resident-Centered Care Plan Format: 3. Goal for care is directly related to the resident's discharge plan (short-term stay focuses on rehabilitation and return to community placement, while long-term stay focuses on helping the resident feel "at home" and maintain/improve ADL abilities, physical and mental wellness, socialization, and overall quality of life)." *"4. Goal date correlates directly to anticipated goal completion or re-evaluation, and/or care conference review. For short-term care residents, goal dates related directly to the discharge plan time frame. Goal dates are set in conjunction with the next quarterly care conference." *"5. Interventions act as the means to meet the individual's needs. The "recipe" for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual goals are being addressed and met.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	1. Immediate action was taken on the proper cleaning of the conventional oven, steam table, shelving, and floors during recertification survey on 3/12/25. Past observations regarding improper glove use and cart cleaning are unable to be remedied. All residents have the potential to be impacted. 2. Administrator or designee will conduct education on Handwashing and Glove Use with Cook/dietary aide (J) and Carts, Shelves and Other Surfaces, Floors/Floor Mats/Baseboards policies with dietary staff on or before 4/21/25. Cleaning schedules and expectations to be reviewed with all dietary personnel on or before 4/21/25. Those associates not in attendance at the education session will be educated prior to their first worked shift. Dietary Manager registered for CFM on 3.5.25.	4/21/2025

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F 812	Continued From page 20 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to follow acceptable food service standards and their policies to ensure one of one kitchen was maintained in a clean and sanitary condition, and proper glove use by cook/dietary aide (J) while preparing and serving residents' food during one observed meal service. Findings include: 1. Observation on 3/11/25 at 5:05 p.m. of serving pans under the steam table in the kitchen revealed: *Food debris and a yellow film on some of the serving pans. *Food debris and a yellow film on three of the pan lids. *Food spatter and a yellow film on the side windows of the steam table. *Food spatter on the undersurface of the top of the steam table where plate covers had been located. 2. Observation on 3/11/25 at 5:15 p.m. of the storage racks next to the stove in the kitchen revealed: *A moderate amount of dust was hanging from the first three racks. *One knife was on the floor under the storage rack. 3. Observation on 3/11/25 at 5:20 p.m. of cook/dietary aide J while serving food revealed:	F 812	3. Administrator or Designee will audit proper glove use to ensure policies and procedures are being followed and maintaining Kitchen cleanliness and proper sanitation. Audits will be conducted weekly x4 weeks and monthly for 2 months. Results of audits will be discussed by Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 812	Continued From page 21 *With his gloved hands he: -Retrieved buttered bread from a bowl and placed it on the resident's plate. -Retrieved a plate from the warming cabinet. -Dished beets and tuna noodle hotdish onto a plate. -Touched a resident's menu slip. -Repeated that same entire process for another resident. *He then removed his gloves, washed his hands, and put on a new pair of gloves. With those gloved hands he: -Retrieved coleslaw from the refrigerator. -Opened a drawer, retrieved a serving spoon, and dished coleslaw into a bowl, and placed a lid on top of that bowl. -Touched a resident's menu slip and then, with those same gloved hands, he repeated the above-observed process of retrieving a slice of buttered bread, dishing food, serving food, and touching resident's menu slips. *Removed his gloves and washed his hands. *He then buttered toasted bread with his bare washed hands. *Cook/dietary aide J put on a pair of gloves. With those gloved hands he: -Opened the refrigerator to retrieve ketchup packets, opened the foil wrapper for a resident's cheeseburger and placed all of those items onto a plate to be served to a resident. 4. Interview with cook/dietary aide J following the above observations revealed: *He agreed that he should not have touched the resident's menu slips and resident food items with the same gloved hands. *He agreed he should not have opened the refrigerator, retrieved ketchup packets, opened the foil, and handled the resident's cheeseburger	F 812		

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F 812	Continued From page 22 with the same gloves on. That was not a clean food service. 5. Observation and interview on 3/12/25 at 10:20 a.m. with dietary manager D in the kitchen revealed: *The carts in the kitchen were to be cleaned daily but sometimes that did not happen. *She agreed a cart had food debris and food spatter on the shelves. *Dietary staff had a cleaning list that should have been completed daily. *She would have reminded staff to clean equipment if the cleaning task had not been completed. *The floors in the kitchen should have been mopped every day. *A knife that was observed under a storage rack on 3/11/25 was still present. -She said that the floor may not have been mopped yesterday (3/11/25). *She agreed that the steam table was not clean. 6. Interview on 3/12/25 at 10:45 a.m. with dietary manager D regarding glove use and food service revealed: *Cook/dietary aide J should have used tongs to retrieve the buttered bread instead of wearing gloves. *Wearing gloves to open the refrigerator door and then touching food items and touching resident's menu slips was not an acceptable food service practice. 7. Interview and observation on 3/12/25 at 2:30 p.m. with administrator A in the kitchen revealed: *Dietary manager D had been sweeping the kitchen floor. *She agreed that there was an observable yellow	F 812		

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F 812	Continued From page 23 residue on the convection oven and the steam table. 8. Interview on 3/13/25 at 8:30 a.m. with administrator A regarding dietary manager certification revealed: *Dietary manager D was taking classes for her dietary manager certification. *The facility did not have a certified dietary manager. Review of the provider's April 2020 handwashing and glove use policy revealed: *"Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food." *"When gloves are used, handwashing must occur prior to putting on gloves and whenever gloves are changed." *"It is important to remember that gloves can often give a false sense of security and can carry germs the same as our hands." Review of the provider's August 2018 Tray Carts, Dish Carts, Utility Carts policy revealed: *"Wash inside (sides, top, bottom, tray guides, and inside of door). Use sanitizing solution and clean cloth." *"Rinse with clean, warm water and clean cloth." *"Allow to air dry." *"Frequency: Weekly."	F 812		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435009	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A recertification survey was conducted on 3/12/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Milbank was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K211, K222, K351, K712, K741 and K920 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain egress paths free of hazards for two randomly observed exits (northeast [500] wing and north dining room exit). Findings include: 1. Observation on 3/12/25 at 2:33 p.m. revealed the exit for the northeast (500) wing had a stoop that was no longer level with the newer concrete installed past the stoop. That joint between the stoop and the rest of the concrete created an	K 211	1. Facility has received quote for correction. Project will be completed at vendor's first availability. All residents have the potential to be impacted by the deficient practice. 2. Administrator or designee will educate the Maintenance department on the maintenance of egress pathways to be free of hazards by 4/21/25. 3. Maintenance Director or designee will audit egress pathways to ensure they are free of hazards monthly for 4 months to ensure that cement is level and there are no other hazards/ obstacles. Maintenance Director or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/discontinuation of audits.	4/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/03/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 1 abrupt level changes of greater than one-quater of an inch within the path of egress. LSC 7.1.6.2 Interview with the maintenance director at the time of the observation confirmed that condition. He stated he was not aware of that condition. The deficiency had the potential to affect 100% of the smoke compartment's occupants. 2. Observation on 3/12/25 at 3:53 p.m. revealed the path of egress for the north dining room exit had new concrete installed past the stoop. The joint between the stoop and the new concrete was not level and created an abrupt level changes of greater than one-quater of an inch within the path of egress. LSC 7.1.6.2 Interview with the maintenance director at the time of the observation confirmed that condition. He stated he was not aware of that condition. The deficiency had the potential to affect 100% of the smoke compartment's occupants.	K 211		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.	K 351	1. The Maintenance Director repaired the hole in the ceiling of the soiled utility room for the 200 wing near a sprinkler head on 3/18/25. All residents have the potential to be impacted by the deficient practice. 2. The Administrator or designee will educate the Maintenance Department on maintaining the fire sprinkler system reaction time as designed by 4/21/25.	4/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435009	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	**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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 2 In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to maintain the fire sprinkler system reaction time as designed in one randomly observed location (soiled utility room for the 200 Wing) Findings include: 1. Observation on 3/12/25 at 11:47 a.m. revealed a hole in the ceiling of the soiled utility room for the 200 Wing near a sprinkler head. That hole was approximately one-foot square and would allow smoke and hot gasses to bypass the sprinkler head and slow the response of the buildings fire suppression system. Interview with the maintenance supervisor at the time of those observations confirmed those findings. He stated he was unaware of that condition. The deficiency had the potential to affect 100% of the occupants of the building.	K 351	3. The Maintenance Director or designee will audit ceiling areas around sprinkler heads weekly x4 weeks then monthly for 2 months to ensure there is no damage that would impact the function of the sprinkler system. Maintenance Director or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/discontinuation of audits.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and	K 712	1. Administrator, IDT and governing board reviewed fire drill policy. Implemented weekly rotating shifts fire drills x 4 weeks and monthly after that. All residents have the potential to be impacted by the deficient practice.	4/21/2025

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	435009	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	1103 SOUTH SECOND STREET MILBANK, SD 57252

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K 712	Continued From page 3 unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (closing corridor doors and checking the door for the fire location). Findings include: Observation beginning on 3/12/25 at 3:04 p.m. revealed a drill for a simulated fire in resident room eight was being conducted. Further observation at that same time revealed the licensed practical Nurse (LPN) F responding to the call light activated in the simulated fire location. LPN F then evacuated the resident from the affected room, closed the door behind them and processed past the smoke doors by the nurse station according to the provider's fire drill procedures. Shortly after the resident had been evacuated, several other staff arrived at the simulated fire location. The staff that responded at that point; entered the room without a fire extinguisher and did not close the resident room doors of the affected smoke compartment (501, 506, 507, and 509). As part of this secondary response, and while being directed of what to do as part of the drill, an agency staff person stated: "I don't know your policy in this building" and neglected to close the door to room 501 at any point. That agency staff person stood in the doorway of that room with the door still open until the conclusion of the fire drill.	K 712	2. Administrator or designee will complete education with all staff on the Fire Drill policy. Education will occur no later than 4/21/25 and staff not present for education will be educated prior to next worked shift. 3. Maintenance Director or designee will complete weekly Fire Drills and audit weekly x 4 weeks, monthly x 2 months. Administrator or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/discontinuation of audits.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435009	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 4 Interview with the maintenance supervisor at the time of the observation confirmed those findings. When asked about the facilities training procedure for staff new to the building, he stated all staff must complete a training course in the "Relias computer training system" that includes fire response procedures. The deficiency had the potential to affect 100% of the occupants.	K 712		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is	K 741	1. The facility purchased self-closing ash trays and placed them in all areas where smoking is permitted on 3/24/25. All residents have the potential to be impacted by the deficient practice. 2. The Administrator or designee will educate all staff that areas of smoking have an ashtray with a self-closing cover. Education will occur no later than 4/21/25 and staff not present for education will be educated prior to the next worked shift. 3. The Maintenance Director or designee will audit the facilities smoking areas for a self-closing cover ashtray weekly x4 weeks then monthly x 2 months. Maintenance Director or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/discontinuation of audits.	4/21/2025

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	435009	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	**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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 5 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to furnish designated smoking areas with a metal container ashtray with a self-closing cover at one randomly observed smoking area. Findings include: 1. Observation on 3/12/25 at 2:50 p.m. revealed a staff person smoking between the walk-in freezer and the north-west (200) wing. That smoking area was not provided with any ashtray. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was not aware of the requirement to provide an ashtray with a self-closing cover in designated smoking areas.	K 741		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435009	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 3/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	1103 SOUTH SECOND STREET MILBANK, SD

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 222	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: A. Based on observation, and interview, the provider failed to provide egress doors as required at one randomly observed location (southwest wing [Oasis wing]). Findings include: 1. Observation at 11:55 a.m. on 12/10/19 revealed the marked exit door at the southwest wing (Oasis wing) was equipped with padlock hasp hardware that could prevent egress and/or require the use of a tool or key to egress. Interview at the time of the observation with the maintenance supervisor confirmed that condition. He stated he was unaware that locking arrangement was an issue. He further stated that hasp was added recently to that exit door as a security measure to lock the door, since that door had no doorknob. He further stated he was

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435009	A. BUILDING: 01 - MAIN BUILDING 01 B. WING	3/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	1103 SOUTH SECOND STREET MILBANK, SD

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 222	Continued From Page 1 unaware this created an issue since that area was not occupied by residents. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100% of the smoke compartment occupants. B. Based on observation, testing, and interview, the provider failed to maintain signage for delayed egress doors as required at two randomly observed exit door locations. Findings include: 1. Observation on 3/12/25 beginning at 1:32 p.m. revealed the exit door from the southeast corridor (400 wing) was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door. That indicated the magnetically locked door was functioning as a delayed egress-locked door. The required signage mounted on the door indicating it was delayed egress and how to exit had been altered such that not all required verbiage was legible. Interview at the time of the observation with the maintenance director confirmed that condition. He stated that door had been that way the entire time he had held his position there. 2. Observation on 3/12/25 beginning at 3:52 p.m. revealed the north exit door from the dining room was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door. That indicated the magnetically locked door was functioning as a delayed egress-locked door. The required signage mounted on the door indicating it was delayed egress and how to exit had been altered such that not all required verbiage was legible. Interview at the time of the observation with the maintenance director confirmed that condition. He stated that door had been that way the entire time he had held his position there. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiencies had the ability to affect 100% of the smoke compartment occupants.
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435009	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 3/12/2025
NAME OF PROVIDER OR SUPPLIER: AVANTARA MILBANK	STREET ADDRESS, CITY, STATE, ZIP CODE: 1103 SOUTH SECOND STREET MILBANK, SD		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 920	Continued From Page 2 general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure extension cords were not used as a substitute for fixed wiring in one randomly observed location (maintenance shop/storage room). Findings include: 1. Observation on 3/12/25 at 2:48 p.m. revealed the westernmost garage door opener in the maintenance shop/storage room had recently been installed. That garage door opener was wired with an extension cord instead of permeant wiring. Interview with the maintenance supervisor at that same time confirmed that finding. He stated he was unaware that condition existed. He further stated that garage door opener had been installed within the last year. The deficiency had the potential to affect 100% of the occupants of that smoke compartment. Ref: 2012 NFPA 101 Section NFPA 101 19.7.4 (6). K222 1. The Maintenance Director removed the padlock hasp on 3/13/25 from the exit door on the southwest wing. The Maintenance Director installed emergency egress signs on both the exit door from the southeast corridor and the north exit door from the dining room on 3/25/25. All residents have the potential to be impacted by the deficient practice. 2. The Administrator or designee will educate the Maintenance department on egress doors being free of locks and/or latches that require a key or tool by 4/21/25. 3. The Maintenance Director or designee will audit the facility's egress doors to ensure they are free of locks and/or latches that require a key or tool weekly x4 weeks then monthly x 2 months. Maintenance Director or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/discontinuation of audits. 4. 4/21/25 K920 1. The Maintenance Director removed the extension cord being used for the western most garage door opener in the maintenance shop on 3/18/25. All residents have the potential to be impacted by the deficient practice. 2. The Administrator or designee will educate the Maintenance department to ensure the facility is not using extension cords as a substitute for fixed wiring by 4/21/25. 3. The Maintenance Director or designee will audit the facility to ensure that no extension cords are being used weekly x 4 weeks then monthly x 2 months. Maintenance Director or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/discontinuation of audits. 4. 4/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435009	A. BUILDING _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 3/12/25. Avantara Milbank was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K. Rubel

TITLE: Administrator

(X6) DATE: 4/03/25

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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10650	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	1103 S SECOND STREET MILBANK, SD 57252

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S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/11/25 through 3/13/25. Avantara Milbank was found not in compliance with the following requirement(s): S427.	S 000		
S 427	44:73:12:23 Wall And Ceiling Finish The facility shall ensure all walls are washable. The finish of walls in the immediate area of plumbing fixtures must be protected from water damage. Wall bases in dietary areas must be free of spaces that can harbor insects. All dietary ceilings must be washable or easily cleanable. This section does not apply to any boiler room, mechanical and building equipment room, shop, or similar space. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview the facility failed to ensure one randomly observed wall bases (under the handwashing sink in the kitchen) was free of spaces that can harbor insects. Findings include: 1. Observation on 3/12/25 at 3:48 p.m. revealed the wall and wall base underneath the handwashing sink in the kitchen had a hole approximately four inches by six inches in size open into the wall cavity that could harbor pests or insects. Interview with the maintenance director at the time of the observation confirmed that condition. He stated he was not aware of that condition.	S 427	1. The Maintenance Director repaired the hole underneath the handwashing sink in the kitchen on 3/17/25. All residents have the potential to be impacted by the deficient practice. 2. The Administrator or designee will educate the Maintenance department that wall bases are free of spaces that can harbor insects by 4/21/25. 3. The Maintenance Director or designee will audit the facility's walls throughout the facility weekly x4 weeks then monthly x 2 months. Maintenance Director or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/discontinuation of audits.	4/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/03/25