

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

PRINTED: 04/27/2022  
FORM APPROVED  
OMB NO. 0938-0391

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|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435009</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                           | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/20/2022</b>   |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AVANTARA MILBANK</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1103 SOUTH SECOND STREET<br/>MILBANK, SD 57252</b> |   |
| (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) |

F 000 INITIAL COMMENTS

F 000

Surveyor: 40506  
A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted 4/20/22. Areas surveyed included corridors, staff areas, utility areas, and resident living spaces. Avantara Milbank was found in compliance.

4/27/22

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

TITLE

(X6) DATE

*[Signature]*

*Administrator*

*4/27/22*

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.

