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 _____	11/08/2023

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 11/6/23 through 11/8/23. Avantara Milbank was found not in compliance with the following requirements: F550, F656, F658, F689, and F880.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	Past observations regarding residents 3, 16, 25, 27 & 35 cannot be corrected. All residents have the potential to be at risk of needing timely hygiene, assistance to the dining room and privacy. All residents are being treated with dignity and respect and have maintained privacy while providing care. The Administrator, DON and interdisciplinary team in collaboration with the medical director will review, revise, create as necessary policy and procedure to ensure all residents are treated in a dignified and respected manner by any and all facility staff whether it be they have food stains on their face and clothing, privacy during bathing and toileting, and spoken to in a respected and pleasant tone and always acknowledged whether waiting for a meal or other cares. The Administrator or designee will provide education and training for all facility staff, including CNA P and PT U, about their roles and responsibilities to ensure all those entrusted to their care and service receive the most dignified and respectful treatment possible by 12/6/23. Those not in attendance will be educated prior to their next shift worked. CNA T was an agency staff person at the time of survey and no longer works at this facility.	12/06/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/28/23

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Offer to assist one of one sampled resident (25) with cleaning his face and changing his clothes when there were visible food stains on them. *Maintain privacy for two of two sampled residents (3 and 16) during bathing and toileting care. *Assist three sampled dependent residents (16, 27, and 35) to the dining room in a timely manner Findings include: 1. Observation and interview on 11/6/23 at 1:52 p.m. with resident 25 revealed: *There was a food stain and bits of crusty food on his sweatshirt and sweatpants. *He had a visible red sauce stain on the left side of his mouth and cheek. *He mentioned, "That must have been from lunch." -He could not remember what he had for lunch. *Resident 25 attempted to wipe the red stain from his cheek, but he was unable to do so. Observation on 11/6/23 at 5:26 p.m. of resident	F 550	The DON or designee will observe randomly, to cover all shifts, a total of 5 residents and 5 staff members' interactions weekly x 4 weeks then monthly x 2 months to ensure residents are clean and well-groomed, assisted timely to the dining room, privacy is maintained during cares and appropriate use of communication is present. Audits will be weekly x 4 weeks then monthly x 2 months. Results of the audits will be presented by the DON or designee to the QAPI committee monthly for discussion of effectiveness and recommendations for at least 3 months. jp 11/28/23	

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25 in the dining room revealed that he still had the red stain on his face, and he was wearing the same clothes.

Review of resident 25's undated care plan revealed:
*There was a focus area of "[Resident 25] requires assistance with ADL's [activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting)."
-Date initiated 5/25/23.
-Revised on 6/30/23.
*The goal was "[Resident 25] will assist with upper body washing and dressing and will allow staff assist with lower body washing and dressing."
-Date initiated 5/25/23.
-Revised on 6/30/23.
-Target date 8/14/23.
*The interventions were as follows:
-"Assist resident with shower/bathing per schedule," initiated on 5/25/23.
-"Encourage participation in ADL's," initiated on 5/25/23.

2. Observation on 11/6/23 at 2:35 p.m. with certified nursing assistant (CNA) T and resident 16 revealed:
*CNA T was pushing resident 16 out of her room in a whirlpool tub chair.
*Resident 16 was covered with a white sheet.
-The white sheet was open in the rear, exposing her buttocks.
*CNA T attempted to fix the sheet and took resident 16 to the whirlpool room.
*CNA T entered the whirlpool room with resident 16 and placed her in the whirlpool.
*CNA T did not shut the door of the whirlpool room while resident 16 was in the tub.

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*CNA T was joined by CNA P who was demonstrating to CNA T how to bathe a resident.

Interview on 11/7/23 at 2:40 p.m. and again on 11/8/23 at 10:18 a.m. with CNA P and CNA T revealed:
*CNA P was training CNA T on how to bathe a resident in the whirlpool tub.
*Each resident should always be covered when leaving their room.
*The door should have been shut while providing care to resident 16.

Interview on 11/8/23 at 10:21 a.m. with assistant director of nursing (ADON) E revealed that it was her expectation that the direct care staff should ensure the residents were fully covered prior to transporting a resident to and from the whirlpool room.

Review of resident 16's electronic medical record (EMR) revealed:
*Relevant diagnoses included:
-Alzheimer's disease.
-Muscle weakness.
-Dysphagia.
-Generalized anxiety disorder.
-Major depressive disorder.

3. Observation on 11/8/23 from 7:45 a.m. to 8:45 a.m. in the main hallway in front of the dining room revealed:
*Residents 16, 27, and 35 were all parked in their wheelchairs just outside the dining room doors.
*Residents 16 and 27 were slumped forward in their wheelchairs. Their eyes were closed, and they appeared to have been sleeping.
-Resident 27 had her fingers in her mouth and was slowly chewing on her right pointer finger.

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*Resident 35 was awake and pleasantly smiling at several staff members as they walked by.
*At least six different staff members walked in and out of the dining room, past the residents, and did not acknowledge any of them or ask if they had eaten breakfast yet.
*At 8:26 a.m., regional nurse consultant (RNC) D asked resident 35 if he had eaten breakfast yet. The resident stated that he had not.
-She told the resident that she would find a staff member to assist him to the dining room for breakfast.
*At 8:35 a.m., an unidentified staff member approached resident 27 and greeted her.
-Resident 27 did not appear to wake up at the greeting.
-The unidentified staff member grabbed the resident's right hand and pulled her fingers out of her mouth saying, "Let's get your fingers out of your mouth."
-That action appeared to startle the resident awake.
-She had been waiting outside the dining room for at least 50 minutes.
*At 8:37 a.m., a staff member brought resident 35 to the dining room for breakfast.
-He had been waiting at least 52 minutes.
*By 8:45 a.m., resident 16 had finally been assisted to the dining room for breakfast.
-She had been sitting outside the dining room for at least 60 minutes.
4. Observation and interview on 11/8/23 at 8:25 a.m. with resident 3 and physical therapist (PT) U revealed:
*Resident 3 was sitting in his wheelchair in his doorway. He was wearing only a shirt and an adult brief.
*The resident attempted to stand up from his wheelchair.

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F 550	Continued From page 5 *PT U was in the room with resident 3. -She assisted the resident with sitting back down into his wheelchair. -As she was attempting to turn the resident around to take him back into his room, she said , "You can't walk by yourself." *After the resident sat back into his wheelchair, she turned the call light on and left the room. -The resident was in full-view from the doorway. -PT U had not covered the resident for privacy before leaving the room, nor did she shut the door. *Resident 3 stood up and walked to the restroom. He was heard using the restroom. *When the resident was finished using the restroom, he walked back into his room, still in full view from the hallway, with only a shirt on. He was naked from the waist down. -He stated, "I wet my pants and I need help." -He laid down in his bed. *At 8:40 a.m., PT U and an unidentified staff member entered the resident's room to assist him. -PT U and the staff member were standing in the resident's doorway, discussing what had happened earlier. -While they were talking in the doorway, the resident was still in full view from the hallway. -They finally stepped into the resident's room and closed the door at 8:42 a.m. Interview on 11/8/23 at 8:55 a.m. with PT U revealed: *As she was walking through the hallway, she saw that resident 3 was sitting in his wheelchair in the doorway to his room with only a shirt and an adult brief on. -She said that the resident was attempting to stand up.	F 550		

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*She had gotten him to sit down and turned on his call light.
*She left the resident's room to find a staff member to assist the resident.

The survey team attempted to interview the unidentified staff member; however, she was not seen again for the remainder of the survey.

Interview on 11/8/23 at 3:43 p.m. with administrator A and ADON E revealed:
*Their expectation was that all residents should have been treated with dignity at all times.
*Residents should have been covered fully when transported to and from the whirlpool room.
*If a resident was undressed, staff members should have closed the door to provide privacy.

5. Review of the provider's September 2019 "Resident Dignity & Privacy" policy revealed:
*"Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy."
*Under the "These guidelines will be followed:" section:
-"3. Respond to requests for assistance in a timely manner."
-"4. Explain care or procedures to the resident before initiating the activity, regardless of resident's cognitive function."
-"5. Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Conversation should be resident-focused and resident centered."
-"6. Groom and dress residents according to resident preference. Clothing should be changed when soiled. Document any resident refusals."

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F 550	Continued From page 7 -"8. Maintain resident privacy - when providing cares, ensure closed doors, window curtains/blinds, divider curtains are closed. When providing peri care or other personal hygiene tasks, only expose the area involved." -"10. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source."	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	Care plans for residents 21, 25 and 30 will be updated to include focused goals, interventions and services specifically related to resident 21's skin integrity, bowel and bladder function and pain, resident 25' s smoking, therapy, prosthetic use, appropriate footwear and advanced directives, and resident 30's behaviors by 12/6/23. All residents may be potentially at risk. All residents' care plans will be reviewed and revised to reflect their current needs by 12/6/23. The Care Planning policy was reviewed with no revisions needed. The DON or designee will educate all care staff including the MDS Coordinator, no later than 12/6/23, on the need to ensure care plans are individualized and reflect resident' s current needs. Those not in attendance will be educated prior to their next shift worked. The IDT will review the prior day's progress notes and clinical alerts each business day morning to identify potential care plan update needs. jp 11/28/23	12/06/23

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F 656	Continued From page 8 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to develop and implement a comprehensive person-centered care plan for three of sixteen sampled residents (21, 25, and 30). Specifically, the provider failed to include focused goals, interventions, and services related to: *Skin integrity, bowel and bladder function, and pain for resident 21. *Smoking, therapy, prosthetic use and appropriate footwear, and advanced directives for resident 25. *Behaviors for resident 30. Findings include: 1. Review of resident 21's undated care plan revealed: *He was admitted on 7/13/23. *There was a focus area that read, "(Interim) Resident has (Specify: potential for/an actual)	F 656	The DON or designee will audit 5 random resident care plans each week to ensure they include individualized focus areas, goals and interventions x 3 months. Results of the audits will be presented the DON or designee to the QAPI committee meeting for discussion of effectiveness and recommendations for at least 3 months.	

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impairment to skin integrity." That was initiated on 7/13/23.
*Another focus area read, "(Interim) Resident is at risk for alteration of bowel and bladder functioning related to: [Specify: Dementia, Catheter use (Foley, Suprapubic, Intermittent), Colostomy/Ileostomy, Urostomy]." That was initiated on 7/13/23.
*The focus area on the last page read, "(Interim) Resident is at risk for pain (Specify: Acute or Chronic) related to (Specify: Arthritis, Neurogenic cause, Ortho surgery, Musculoskeletal issues, Other: specify)." That was initiated on 7/13/23.
*There was no indication that the above-described focus areas on resident 21's care plan had been revised to have been specific to that resident.

2. Review of resident 25's undated care plan revealed:
*He was admitted on 5/25/23.
*There were no focused goals, interventions, or services described related to his smoking habits.
*There was a focus area that read, "[Resident 25] is at risk for falls related to Rt BKA [right below-the-knee amputation] Cognitive impairment, Impulsivity and poor safety awareness."
-Date initiated 7/3/23.
-Revised on 7/3/23.
-There were other interventions that indicated his amputation was on his left leg.
*The associated interventions were listed as follows:
-"Ensure that (Specify: Name)is wearing appropriate footwear (Specify and describe correct client footwear i.e. [that is] brown leather shoes, tartan bedroom slippers, black nonskid socks) when ambulating or mobilizing in w/c

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[wheelchair]."
--Date initiated 7/3/23.
-"I need continued skilled therapy intervention to improve my strength and endurance."
--Date initiated 7/3/23. There was no revision date.
*There was a separate focus area for his advanced directives, which indicated he wished for DNR (do not resuscitate).
-Two associated interventions did not correctly identify his wishes for DNR.

Observation and interview on 11/6/23 at 2:19 p.m. with resident 25 revealed:
*His left lower leg had been surgically amputated earlier that year.
*He had a prosthetic left leg.
*He confirmed that he used cigarettes and that he was not receiving physical or occupational therapy.

Interview on 11/8/23 at 8:20 a.m. with physical therapist U about resident 25 revealed:
*She confirmed that resident 25 was not receiving physical therapy services.
*She provided all of resident 25's physical therapy notes, which revealed he had only been seen and evaluated on 7/5/23.
-Resident 25 had not received any therapy services since 7/5/23.

3. Review of resident 30's undated care plan revealed:
*He was admitted on 10/27/22.
*There was a focus area that read, "[Resident's name] has dx of delirium from....." That was initiated and revised on 10/30/23.
-The associated goal read, "[SPECIFY: Name/I] will be free of signs or symptoms of delirium

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(changes in behavior, mood, cognitive function, communication, level of consciousness, restlessness) through [SPECIFY TIME PERIOD]." That was initiated on 10/30/23 and had a target date of 11/30/23.
-There were no associated interventions for the delirium focus area.

4. Interview on 11/8/23 at 8:45 a.m. with regional nurse consultant (RNC) D about resident care plans revealed:
*It was her expectation for care plans to have been personalized for each resident.
*She indicated that the facility's resident care plans have room for improvement.
*For resident 25, she would have expected there should have been a section on his care plan regarding his smoking habits.

Interview on 11/8/23 at 11:11 a.m. with Minimum Data Set (MDS) coordinator J about resident care plans revealed:
*She was aware of the issues with resident care plans.
*Her main job was to coordinate the MDS assessments, in addition to maintaining the resident care plans.
*Care plans were to have been updated at least quarterly and as needed.
*She confirmed that resident 25 was not receiving any therapy services.
-He was a private-pay resident, so the physical therapist only conducted their initial evaluation on 7/5/23.
*When she created a resident's care plan, she included triggered-focused areas from the MDS assessments and the associated care area assessments.
*She also included relevant diagnoses,

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medications, and any behavioral concerns.

Interview on 11/8/23 at 1:57 p.m. with RNC D and assistant director of nursing E about resident 30's care plan revealed:
*Resident 30 had a diagnosis of dementia and at times became agitated.
*They would have expected his care plan to include the resident's behavior patterns and interventions for staff to address the behaviors.
*They confirmed that resident 30's care plan was incomplete.

Interview on 11/8/23 at 2:03 p.m. with MDS coordinator J about resident 30's care plan revealed:
*She was puzzled as to why his care plan included a focus area of delirium, as resident 30 had not shown any signs or symptoms of delirium.
*She confirmed that his care plan was incomplete and should not have included a focus area of delirium.

5. Review of the provider's September 2019 "Care Planning" 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, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations."
-" ...3. Care planning is constantly in process; it begins the moment the resident is admitted to the

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facility and doesn't end until discharge or death."
-"4. Each resident is included in the care planning process and encouraged to achieve or maintain their highest practicable physical and mental abilities through the nursing home stay."
-"5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total 'plan of care.' Physician's orders are referenced in the resident's care plan, but not rewritten into that care plan."
-"6. The DON [director of nursing] will be responsible for holding the team accountable to initiating and completing the Admission care plan within 48 hours and the long-term care plan by day 21 and updates as necessary thereafter."
*Under the "Resident-Centered Care Plan Format" section:
-" ...2. Data/Problems/Needs/Concerns are a culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking, pattern identification, and personal information forming the foundation of the care plan."
-"The care plan is broken down into separate focus areas: Psycho-Social, Quality of Life, Comfort/Pain/Sleep, Death & Dying, Behavior, Communication, Nutritional Status, Bowel & Bladder Function, Hygiene ADL's/Skin [activities of daily living], Safety/Vulnerability, Mobility/Fall Prevention, Medications and Special Attention for Other Physical Conditions."
-"3. Goal for care are 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

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of life)."
-" ...5. Interventions act as the means to meet the individual's needs (not to continue outmoded institutional practices). The 'recipe' for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met. Assessment tools are used to help formulate the interventions (they are not THE intervention)."
*"Procedure:"
-"1. Each interdisciplinary team member is educated during orientation and at least annually thereafter about assessment and care planning per each department's role in the process. Each staff member working with the individual resident is responsible to read, utilize and offer input to improve the care plan content ongoing."
-" ...4. Each department supplies information and input into all areas of the care plan as they obtain information (Note: no one section is completely dedicated to any one department).
-"The formal care plan (multi-page) is completed/updated by the interdisciplinary team (IDT) members prior to the care conference. The IDT signatures are recorded electronically for the sections(s) the individual completes. The plan is then reviewed by IDT during the care conference."
-"Resident care conferences are held within the first 72 hours of admission, upon completion of the comprehensive care plan and at least quarterly thereafter in coordination with the MDS schedule and process."
-"5. After the care conference, if there are any revisions needed, they are made in the EHR [electronic health record] care plan."
-" ...8. Care Plans should be updated between care conferences to reflect current care needs of

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F 656	Continued From page 15 the individual resident as changes occur." Review of the provider's September 2019 "Smoking" policy revealed: *"Procedures: ...If the facility allows smoking, all residents who smoke will be assessed for their ability to safely smoke with or without assistance or supervision and such will be included on the care plan ..." *"Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the resident's individual care plan." *"The care plan will indicate how the smoking materials will be stored, i.e, stored by resident, stored by and distributed by facility staff, or maintained by other means."	F 656		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and record review, the provider failed to clarify one of one sampled resident's (35) medication dosage from a physician's order which resulted in the resident receiving 8 times the intended prescribed dose of an antipsychotic medication for 14 days, which potentially contributed to his increased lethargy during that time. Findings include: 1. Observation and interview on 11/6/23 at 2:19	F 658	No correction can be made to past observation of administered topical medication for resident 12 or not clarifying ordered dose of a medication for resident 35. Resident 12's and Resident 35's medication/medication dose has been clarified. All residents may have the potential to be at risk. All residents' rooms will be observed for medications and moved to the medication carts, if any. Discrepancies in orders, labeling or storage, if any, will be communicated to the resident's physician for clarification and/or the pharmacy for labeling if applicable.	12/06/23

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F 658	Continued From page 16 p.m. with resident 35 revealed: *He was hard of hearing and could not answer questions. *He was sitting in a Broda chair. *He appeared very thin, his eyes and temples were sunken, and was calling for his mother and father. 2. Review of resident 35's electronic medical record (EMR) revealed: *He was admitted on 4/13/23. *Relevant diagnoses included unspecified dementia, diffuse traumatic brain injury, and bilateral hearing loss. *A 9/14/23 physician's fax order for "Start Zyprexa 205 mg [milligrams] po [orally] BID [twice daily]" from a hospital in Sioux Falls. *The physician's order that was entered into the resident's EMR on 9/14/23 was for 20 mg, not 205 mg as the faxed physician's order had read. *He received 20 mg of Zyprexa twice daily from 9/14/23 to 9/28/23. *He experienced increased episodes of lethargy between 9/14/23 when the Zyprexa was started, to 9/28/23 when the Zyprexa order was decreased. *A nurse's progress note from 9/28/23 at 4:21 p.m. indicated, "Writer had phone conference today with the [hospital] team. During conference writer was informed that on the notes that we received 2 weeks ago ...there was a typo. Order was supposed to be for [Zyprexa] 2.5mg BID. [Hospital team] stated this is why he is having so many episode[s] of lethargy. Orders received today was to decrease [Zyprexa] to 2.5mg TID [three times daily]." *A 9/28/23 physician's order for "Reduce olanzapine [Zyprexa] to 2.5 mg po TID" from the same hospital in Sioux Falls.	F 658	The Administrator, DON, and interdisciplinary team in collaboration with the medical director and the pharmacy consultant will review, revise, create as needed the policy and procedure to verify order accuracy and need for physician order reflecting medication being administered, including to review how orders are received and verified before entered on MAR and that there is an order for medication being administered. The orders process has been revised to have all orders reviewed by 2 nurses for verification and accuracy. The DON or designee will provide education and training for LPN F, ADON E, and all staff responsible for receipt of orders, verification, medication administration and accuracy of orders about their roles and responsibilities to ensure the rights of medication administration are carried out by 12/6/2023. Those not in attendance will be educated prior to their next shift worked. The DON or designee will perform audits each business day to ensure all physician orders were verified by 2 nurses and entered into the electronic medical record accurately x 3 months and will audit 5 random resident rooms weekly x 4 weeks, then monthly x 2 months to ensure no medications are stored in their rooms unless ordered for self-administration and to store in resident's room. Results of the audits will be presented by the DON or designee to the QAPI committee monthly for discussion of effectiveness and recommendations for at least 3 months. jp 11/28/23	

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*The resident had received eight times the intended prescribed dose of Zyprexa from 9/14/23 to 9/28/23.

3. Interview on 11/8/23 at 10:22 a.m. and again at 3:28 p.m. with assistant director of nursing (ADON) E revealed she:
*Confirmed she had entered the order for Zyprexa as 20 mg BID on 9/14/23.
*Should have clarified the physician's order from 9/14/23 as the initial faxed physician's order for 205 mg was out of the ordinary.
*Confirmed she had not called the physician to clarify the order.

Interview on 11/8/23 at 2:51 p.m. with Administrators A and B revealed their expectation was that all medication orders that were out of the normal dosage for a medication should have been clarified prior to administration of that medication.

4. A policy for resident prescription verification was verbally requested on 11/8/23 at 3:30 p.m. from ADON E. She indicated there was no such policy.
B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident's (12) medicated topical cream had a physician's order. Findings include:

1. Observation on 11/7/23 at 8:30 a.m. of licensed practical nurse (LPN) F during the medication administration revealed:
*Certified nursing assistant (CNA) staff had approached LPN F and explained that resident 12 had requested BioFreeze cream to her right hip and upper right thigh.

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*LPN F had stated that the resident had a different cream that she preferred to use in the resident's room.
*Upon entering resident 12's room, LPN F searched and eventually found a tube of "Arthritis Relief Pain Relieving Cream with Aloe" on the resident's bedside table.
*After confirming with resident 12 that the tube of cream was hers, LPN F administered the topical cream.

2. Review of resident 12's EMR revealed:
*She had a physician's order for the BioFreeze.
*There was no order for the "Arthritis Relief Pain Relieving Cream with Aloe" that LPN F had administered.
*There was no documentation on the treatment administration record (TAR) or medication administration record (MAR) that the "Arthritis Relief Pain Relieving Cream with Aloe" was to have been administered to the resident.

3. Observation on 11/8/23 at 8:53 a.m. in resident 12's room revealed:
*A basket was sitting next to the sink that contained a tube of cream stacked on top of various lotions.
*The label on the tube of cream identified it as "Arthritis Relief Pain Relieving Cream with Aloe" 10% trolamine salicylate.
*There was no label on the tube indicating whose cream it was.
*There was no date written on the tube indicating when the cream had been opened.

4. Interview on 11/8/23 at 10:09 a.m. with LPN F revealed:
*Resident 12 had a physician's order for the BioFreeze but the resident did not like the cold

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sensation or the smell of the BioFreeze.
*She would make a note in the resident's medical record that the cream had been administered.
*She agreed that there was no physician's order for the "Arthritis Relief Pain Relieving Cream with Aloe."
*She agreed that the "Arthritis Relief Pain Relieving Cream with Aloe" should not have been stored in the resident's room.

Interview on 11/8/23 at 2:44 p.m. with ADON E and regional nurse consultant D revealed they agreed that there should have been a physician's order for the arthritis cream found in resident 12's room and that it should not have been kept in her room.

5. Review of the providers undated MEDICATION STORAGE IN THE FACILITY policy revealed:
*"B. Administration
*1. Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications.
*2. Medications are administered in accordance with written orders of the prescriber."
*"D. Documentation (including electronic)
*"3. Topical medications used in treatments are listed on the treatment administration record (TAR/e[electronic]TAR).
*"4. The resident's MAR/e[electronic]MAR is initialed by the person administering the medication ..."
*"5. When PRN [as needed] medications are administered, the following documentation is provided:
*a. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site.

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F 658	Continued From page 20 *b. Complaints or symptoms for which the medication was given. *c. Results achieved from giving the dose and the time results were noted. *d. Signature or initials of [the] person recording administration and signature or initials of person recording effects, if different from the person administering the medication."	F 658		
F 689 SS=G	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 interview, observation, record review, and policy review, the provider failed to adequately assess one of four resident's (43) ability to safely smoke unsupervised that resulted in the resident falling outside on two separate occasions and sustaining head injuries. Findings include: 1. Interview on 11/7/23 at 3:56 p.m. with registered nurse (RN) V about the residents who smoked revealed: *None of the residents who chose to smoke were supervised while they were outside. -They had been evaluated and determined to be safe to smoke independently. *It was the expectation that the residents were responsible for notifying staff when they wanted	F 689	Resident 43 was assessed for smoking safety on day of admission to the facility on 9/22/23 per policy and was found safe to smoke independently without supervision. Resident 43 was evaluated by a physician on 10/2/23 following a fall and returned with orders to not give sedating medications before in bed for the evening and [has] had final trip outdoors for the night. Order was processed and has been followed. Resident 43 has not had any falls while smoking since. Resident was again assessed for smoking safety on 10/4/22 and was found to be safe to smoke independently without supervision. All residents who choose to smoke may potentially be at risk.	12/06/23

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F 689	Continued From page 21	F 689	A smoking safety assessment will be completed on all residents who choose to smoke by 12/6/23. Such residents have been provided individual key fobs for the smoking area door. A resident monitoring company will be contacted to obtain a wireless call light system to be installed upon their earliest ability to do so. Until that system is installed, such residents will be provided a wireless doorbell pendant to alert staff for assistance if needed while outside. Signage is in place to direct appropriate disposal of smoking items. All residents who choose to smoke will be educated on the smoking policy and process by the DON or designee by 12/6/23. The Administrator, DON, and interdisciplinary team in collaboration with the medical director will review, revise, create as needed the policy and procedure to ensure any and all residents identified as smokers, have thorough and accurate assessment about their safety while smoking that includes a need for supervision when smoking and review risk factors that may contribute to accident potential. The smoking assessment tool has been updated with a section of additional contributing factors to potential hazards including medical diagnoses, medications and listing medication side effects that may contribute to potential accident hazards. The Administrator or designee will provide education and training by 12/6/23 for all facility staff that may observe or assist resident(s) with smoking activity. Education and training should include role and responsibility as licensed or unlicensed staff member. Those not in attendance will be educated prior to their next shift worked. jp 11/28/23	

to be let back inside via the doorbell on the wall outside.
*The doorbell was out of the resident's reach if they were to have fallen outside.

Interview on 11/8/23 at 8:58 a.m. with licensed practical nurse (LPN) F about the residents who smoked revealed:
*Resident 43 had fallen "at least twice" while outside smoking in the courtyard.
*She said, "We don't have enough staff to have someone sit out there to supervise."

2. Observation on 11/8/23 at 9:59 a.m. revealed that resident 43 was outside in the courtyard smoking without any supervision.

Observation on 11/8/23 at 10:10 a.m. in the courtyard revealed:
*There was a doorbell on the wall to the left of the door.
-When pressed, a doorbell sound was audible inside.
*There was one glass ashtray available with several cigarette butts and ashes in the tray.
*There were two lawn chairs and one bench just outside the patio door.
*A white plastic garbage can with a lid and a plastic liner was to the left of the door.
-The garbage can was filled with empty cigarette cartons and visibly burnt, used cigarette butts.
*A red metal bucket with a lid was to the left of the corner of the building.
-Inside the bucket, there were several visibly burnt, used cigarette butts and cigarette ashes.

3. Interview on 11/8/23 at 10:19 a.m. with regional nurse consultant (RNC) D about the provider's smoking rules and resident 43's falls revealed:

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F 689	Continued From page 22 *She explained that resident 43 had fallen because directly before going outside to smoke, the resident had been given her bedtime medications. -Resident 43 became dizzy due to her medications. As a result, she fell and hit her head. *She confirmed that staff now give the resident her bedtime medications after her final cigarette for the day. *Resident 43 was assessed for smoking safety and was determined to not need supervision while smoking outside. *They had discussed with the residents previously about establishing a smoking schedule to provide more supervision; however, the residents were not in favor of a schedule. *She was not aware that residents had been placing their burnt and used cigarette butts in the white garbage can. She confirmed that was an unsafe practice due to the risk of a fire. 4. Review of the resident's electronic medical record revealed that she was hospitalized overnight from 9/29/23 to 9/30/23, and again on 10/1/23 to 10/2/23 due to her falls. Review of a nurse's progress note on 9/29/23 at 11:21 p.m. revealed: *"Resident left the facility per ambulance at 2315 [11:15 p.m.]. Dr. [name redacted] [gave order] to have a scan completed due to resident's complaint of severe [head pain] and she is currently taking Eliquis [an anticoagulant medication]." *There were no other progress notes with a description of the fall from 9/29/23. *She returned to the facility on 9/30/23 at 2:30 a.m.	F 689	The DON or designee will audit/observe all residents who smoke at random times 3 times weekly x 4 weeks for safe smoking practices, then weekly x 2 months. Results of the audits/observations will be presented by the DON or designee to the QAPI committee monthly for discussion of effectiveness and recommendations for at least 3 months.	

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Review of the resident's hospital discharge paperwork that was sent to the facility on 9/30/23 at 1:24 a.m. revealed the "clinical impressions" included "contusion of head" and "acute hip pain."

Review of the resident's September 2023 medication administration record (MAR) revealed she received the following medications at 8:00 p.m. per physician's orders on 9/29/23:
*"tiZANidine HCl Oral Tablet [a muscle relaxant] 4 MG [milligrams] Give 1 tablet by mouth at bedtime for muscle spasms."
*"traZODone HCl Oral Tablet [an antidepressant and sedative] 50 MG Give 0.5 tablet by mouth at bedtime for Insomnia."
*"Zolpidem Tartrate Oral Tablet [a sedative] 5 MG Give 2 tablet by mouth at bedtime for Insomnia."
-Only one tablet was administered.

Review of the resident's October 2023 MAR revealed she received the following medications at 8:00 p.m. per physician's orders on 10/1/23:
*"tiZANidine HCl Oral Tablet 4 MG Give 1 tablet by mouth at bedtime for muscle spasms."
*"traZODone HCl Oral Tablet 50 MG Give 0.5 tablet by mouth at bedtime for Insomnia."
*"Zolpidem Tartrate Oral Tablet 5 MG Give 2 tablet by mouth at bedtime for Insomnia."

Review of a medication administration note on 10/1/23 at 7:41 p.m. revealed:
*"Note Text: LORazepam Oral Tablet 0.5 MG. Give 1 tablet by mouth every 4 hours as needed for anxiety and agitation for 14 Days. resident request for anxiety."

Review of an incident note on 10/1/23 at 11:30 p.m. revealed:

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	435009	A. BUILDING _____ B. WING _____	11/08/2023

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 689	Continued From page 24	F 689		

*"Incident Summary: Called to patio outside facility where resident had been [to go] out for a cigarette. Resident is observed lying on the concrete on her [right side] propped up by her elbow. Her seated walker is behind her."
*"Resident reports that she hit her head and has [a headache]. She said she got 'dizzy' and fell."
*"Resident is observed for injury. Lump to back right side of her head is noted."
*"Small amount of blood with bruising is seen. Resident is [sic] staff assisted to her walker and brought back into the facility. VS [vital signs] are obtained and neuro checks are initiated."
*"Calls placed to [name redacted] POA [power of attorney] at 2119 [9:19 p.m.] and resident's [ex-spouse] to inform her of resident's fall."
*"Resident was declining to be seen and was showing signs of confusion, agitation and hypotension. With some encouragement resident did agree to go to [the hospital] to be evaluated."
*"DON [director of nursing], ADON [assistant director of nursing], Administrator and Regional Nurse consultant were notified at 2056 [8:56 p.m.] of fall. Notified again at 2203 [10:03 p.m.] of resident being sent to [the hospital] for evaluation. Resident was sent via EMS [emergency medical service] at 2215 [10:15 p.m.]."

Review of the resident's hospital discharge paperwork that was sent to the facility on 10/2/23 at 12:24 a.m. revealed:
*The "clinical impressions" included "contusion of head" and "concussions."
*The "patient specific instructions" read, "Do not give zolpidem, [A]tivan, tizanidine, trazodone or any other sedating medications before patient is in bed for the evening and had her final trip outdoors for the night. Patient appears to have concussion from multiple falls. Headache,

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confusion are to be expected ..."

Review of resident 43's undated care plan revealed:
*She was admitted on 9/22/23.
*Relevant diagnoses included absence epileptic syndrome, not intractable, without status epilepticus [a seizure condition in which the person stops all activity, and appears to be staring into space, may affect the person's situational awareness, does not last longer than five minutes, and is able to be controlled by medications]; nicotine dependence; vitamin D deficiency; hypothyroidism; essential hypertension; depression; chronic obstructive pulmonary disease; immune thrombocytopenic purpura; anxiety disorder; type 1 diabetes mellitus with diabetic neuropathy; insomnia; unspecified severe protein-calorie malnutrition; portal hypertension.
*There was the following intervention: "The resident has been assessed according to facility policy and has been determined to be a safe smoker, capable of following the applicable rules." That was initiated on 9/22/23.
*There was no documentation in her care plan that she had sustained falls with injury while smoking or any additional precautions staff should have taken regarding safe smoking, such as administering her bedtime medications after her final cigarette for the day.

Review of the resident's assessments titled "Smoking Program (Evaluation for Risk) - V 2" completed on 9/22/23 and again on 10/4/23 revealed:
*The following statement was check-marked with both assessments: "Resident is considered a safe smoker and May use/access smoking

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materials consistent with facility policy. Staff is not required to remain in attendance while resident is smoking. RESIDENT AGREES TO FOLLOW SMOKING RULES."
*The assessments had not taken into consideration contributing factors to smoking safety such as risk for falls, diagnoses, or medications that might have put the resident at risk for accidents while smoking.

5. Review of the provider's September 2019 "Smoking" policy revealed:
*"Policy: This facility shall establish and maintain safe resident smoking practices while protecting the rights of the individual resident."
*"Facilities, at their discretion, may not allow smoking on their premises or may allow smoking only when the resident requires no supervision to smoke, or may offer smoking times and supervised smoking only."
*"Procedures: ...If the facility allows smoking, all residents who smoke will be assessed for their ability to safely smoke with or without assistance or supervision and such will be included on the care plan. The Smoking Assessment will be completed at admission, readmission quarterly, annually, and with a change in condition."
-"a. Facility will provide staff, family or volunteer supervision when assessment determines supervision is required ..."
-"b. The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision."
*"Designated smoking areas include:"
-" ...e. A suitable number of noncombustible ashtrays will be provided in smoking areas."
--"1. To reduce the potential for a burning cigarette to fall out of the ashtray and onto nearby

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F 689	Continued From page 27 combustibles, only ashtrays designed with holders inside the ashtray will be used." --"2. Cigarettes or other smoking materials will not be left unattended in ashtrays." -"g. Smoking areas will be provided with metal containers equipped with self-closing covers to be used solely for the disposal of cigarette butts and ashes." --"1. A sign to that effect will be posted on the containers." --"2. All cigarettes and other smoking materials will be promptly disposed of in these containers and are not allowed to be discarded elsewhere." *"The staff shall consult with the Attending Physician and the Director of Nursing to determine any restrictions on a resident's smoking privileges." *"Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the resident's individual care plan."	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	Directed Plan of Correction Avantara Milbank F880 Corrective Action: 1. For the identification of: *Lack of appropriate hand hygiene and glove use with preparing and serving food. *Lack of appropriate storage of staff consumed beverages in food preparation areas. *Lack of hand hygiene after staff cough during food service.	12/06/23

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F 880	Continued From page 28 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	The administrator, DON, infection control nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 12/6/2023 by the Certified Dietary Manager or designee. Any staff not in attendance will be educated prior to their next shift worked. Identification of Others: 2. ALL residents being served a meal have potential impact for lack of appropriate processes and follow through for the above identified items. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 12/6/23 by the Certified Dietary Manager or designee. Any dietary staff not in attendance will be educated prior to their next shift worked.	

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F 880	Continued From page 29 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection control practices were followed for the following: *Two of two staff (administrator A and cook M) who kept their personal beverages in the food preparation areas. *One of one observed certified nursing assistant (CNA W) who coughed into her arm and continued serving food without performing hand hygiene. *One of three food service staff (cook M) had worn gloves and performed hand hygiene while preparing and serving food. Findings include: 1. Observation on 11/6/23 at 5:37 p.m. during the supper service in the kitchen revealed: *There was an opened can of an energy drink with a straw through the opening on the food preparation counter. -Cook M was in the kitchen serving the resident's food from the steam table that was connected to the food preparation counter. -She had taken a drink from the can and then continued with serving the meals without performing hand hygiene.	F 880	System Changes: 3. Root cause analysis determined staff were nervous during the survey process which led to the above lapses in infection control practices. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Administrator contacted the South Dakota Quality Improvement Organization (QIO) on 11/22/23. The root cause analysis and this plan of correction were discussed. The QIO agreed with this plan of correction and provided resources that may be used as tools in continued staff education. Monitoring: 4. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee	

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-The can of energy drink remained on the counter next to the steam table throughout the rest of the food service.

Interview on 11/8/23 at 2:44 p.m. with assistant director of nursing/infection preventionist E and regional nurse consultant D revealed:
*Kitchen staff were not allowed to have beverages in the food service area.
*The staff were allowed to keep their beverages in the office in the kitchen.
*They agreed that the kitchen staff should not have been drinking beverages in the middle of food service and that the beverage should have been in the office off the kitchen, and not on the food preparation counter while serving food.

Observation and interview on 11/8/23 at 3:30 p.m. in the kitchen with administrator A revealed:
*A water jug was on the food preparation counter next to the steam table.
*Administrator A was chopping vegetables for the evening meal service.
*He confirmed that the water jug was his.
*He agreed that the water jug should have been in the office off the kitchen and not in the food preparation area.
2. Observation on 11/6/23 at 5:44 p.m. of CNA W in the dining room revealed:
*She was removing trays of resident's food from a mobile cart.
*At one point, she coughed into the bend of her left arm.
-Without performing hand hygiene or cleaning her arm, she served resident 18 his meal.
*She used hand sanitizer after serving resident 18. She did not sanitize or clean her arms.

3. Observation on 11/7/23 at 5:07 p.m. of cook M

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revealed:
*She was measuring the temperature of the egg rolls for dinner.
-She was wearing gloves.
*She removed that pair of gloves. Without performing any hand hygiene, she put on a clean pair of gloves and then started to cut tomatoes.
*She removed the second pair of gloves after cutting the tomatoes. Without performing hand hygiene, she put on a clean pair of gloves and started to place shredded cheese on a salad.
*She removed the third pair of gloves. Without performing hand hygiene, she put an oven mitt on her hand and placed a pan in the oven.
*Afterwards, without performing hand hygiene she used her ungloved left hand to place bread onto a sandwich.

Interview on 11/7/23 at 5:18 p.m. with cook M revealed she:
*Was aware that she was supposed to perform hand hygiene between each glove change.
*Confirmed she had not performed hand hygiene between any of her glove changes.
*Had not noticed that she had used an ungloved hand to put the bread on the sandwich.

4. Review of the provider's 4/15/20 "HANDWASHING AND GLOVE USE" policy revealed:
*"Policy: Guidelines for handwashing and glove use to promote safe and sanitary conditions throughout the Food and Nutrition Services Department must be followed."
*"Procedure: Handwashing"
-"1. Handwashing is a priority for infection control."
-"2. Hands must be washed ...when working with different food substances i.e. raw chicken to fresh

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fruit, and following contact with any unsanitary surface i.e. touching hair, sneezing, opening doors, etc."
*"Gloves"
-"1. Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food."
-"2. When gloves are used, handwashing must occur per above procedure prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed ... Gloves may be used for one task only."

Review of the provider's 5/6/21 "PERSONAL HYGIENE/SAFETY/FOOD HANDLING" policy revealed:
*"Policy: Guidelines for personal hygiene to promote a safe and sanitary department must be followed."
*Under the "Procedure" section:
-"2. Clean Hands, Fingernails, and Gloves"
--" ...b. Hands must always be washed after ...handling any unsanitary items."
--" ...g. Gloves should be used when touching ready-to-eat (RTE) foods. RTE foods are foods that will not receive additional cooking. Examples of RTE foods are sandwiches, salads, ice, and similar foods. Utensils such as scoops, tongs, or ladles can also be used to handle RTE foods."
-"4. Conduct"
--" ...c. Eating and drinking are not permitted in food preparation and service areas."

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

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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 from 11/6/23 through 11/8/23. Avantara Milbank was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/24/23

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	435009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/07/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/7/23. Avantara Milbank was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K211, K363, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=D	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, testing, and interview, the provider failed to provide operable egress doors as required at one randomly observed exit door location (the north dining room). Findings include: 1. Observation beginning on 11/7/23 at 11:39 a.m. revealed the north dining room exit door was unable to be easily opened. Testing of the door by applying greater than fifty pounds of force in the direction of the path of egress revealed it would not open.	K 211	The north dining room exit door was repaired and remains to working as designed on 11/24/23 Action to address other potential patient/areas: House wide audit to be conducted on all doors to ensure proper function by 12/6/2023. All doors found outside of requirements will be repaired or adjusted upon discovery. Administrator or Designee will educate Maintenance Director in regards to requirements of corridor and exit doors by 12/6/2023 All doors and locks will be inspected for appropriate function weekly ongoing as part of the facility preventive maintenance program by the facility Maintenance Department or designee.	12/06/23

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

TITLE: Administrator

(X6) DATE: 11/24/23

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K 211	Continued From page 1 Interview at the time of the observation with the maintenance director confirmed those conditions. He stated he was unaware that door was not able to be opened. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)	K 211	Administrator or designee will audit preventative maintenance program documentation weekly times 90 days to ensure completion. Administrator or designee will audit 5 doors weekly times 90 days to ensure proper function. Audits will be reported to the QAPI Committee monthly for further analysis and recommendations, until such time that the QAPI Committee	
K 363 SS=C	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363	Corridor door to the breakroom repaired and working as designed on 11/24/2023 Action to address other potential resident/area: House wide audit to be conducted on all doors to ensure proper function by 12/6/2023. All doors found outside of requirements will be repaired or adjusted upon discovery. Administrator or Designee will educate Maintenance Director in regards to requirements of corridor and exit doors by 12/6/2023 All doors and locks will be inspected for appropriate function weekly ongoing as part of the facility preventive maintenance program by the facility Maintenance Department or designee.	12/06/23

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	11/07/2023

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 363	Continued From page 2 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain doors with positive latching for two randomly observed corridor doors (employee breakroom and clean linen room) as required. Findings include: 1. Observation on 11/7/23 at 10:24 a.m. revealed the corridor door to the employee breakroom was not latched into the door frame. Testing of that door at that same time revealed the doors automatic closer would not provide enough force to positively latch the door into the frame for 4 of 5 attempts. Interview with the maintenance director at the time of the observation and testing confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363	Administrator or designee will audit preventative maintenance program documentation weekly times 90 days to ensure completion. Administrator or designee will audit 5 doors weekly times 90 days to ensure proper function. Audits will be reported to the QAPI Committee monthly for further analysis and recommendations, until such time that the QAPI Committee determines that compliance has been met and sustained	

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 _____	11/07/2023

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AVANTARA MILBANK	1103 SOUTH SECOND STREET MILBANK, SD 57252

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K 363	Continued From page 3 2. Observation on 11/7/23 at 11:38 a.m. revealed the corridor door to the clean linen room was not latched into the door frame. Testing of that door at that same time revealed the doors automatic closer would not provide enough force to positively latch the door into the frame for 5 of 5 attempts. Interview with the maintenance director at the time of the observation and testing confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363		
K 712 SS=F	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 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 record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 11/7/23 at 1:15 p.m. revealed	K 712	Corrective Action: Facility will ensure fire drills are completed monthly and one per shift per quarter. Second shift fire drill will be completed by 12/6/23 The Administrator/designee will educate maintenance department on requirements for fire drills to be monthly and one per shift per quarter in accordance with life safety code by 12/6/23	12/06/23

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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	11/07/2023

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K 712	Continued From page 4 there was no documentation of any second shift (2:15 p.m. - 10:30 p.m.) fire drills for quarters one through three (January-September) of 2023, Further observation at that same time revealed there was no documentation for third shift (10:15 p.m. - 6:30 a.m.) fire drills for quarters one and two (January-July) of 2023. Interview with the maintenance director at the time of the record review confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712	Monitoring: Facility Administrator or designee will conduct audits of fire drill documentation to ensure drills meet life safety code requirements monthly times 90 days. Audits will be reported to the QAPI Committee monthly for further analysis and recommendations, until such time as the QAPI Committee determines that compliance has been met and sustained.	

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 _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	1103 S 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) COMPLETE DATE
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 11/6/23 through 11/8/23. Avantara Milbank was found not in compliance with the following requirement: S169.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure an electrically audible alarm was provided for one randomly observed exit door to the exterior (employee breakroom exit door). Findings include: 1. Observation on 11/7/23 at 10:24 a.m. revealed the corridor door to the employee breakroom had	S 169	Corrective Actions: Corridor door to the breakroom repaired and working as designed on 11/24/2023 Exit door in breakroom repaired and working as designed on 11/24/23 Action to address other potential resident/area: House wide audit to be conducted on all doors to ensure proper function by 12/6/2023. All doors found outside of requirements will be repaired or adjusted upon discovery. Administrator or Designee will educate Maintenance Director in regards to requirements of corridor and exit doors by 12/6/2023 All doors and locks will be inspected for appropriate function weekly ongoing as part of the facility preventive maintenance program by the facility Maintenance Department or designee.	12/06/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/24/23

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	10650	A. BUILDING: _____ B. WING _____	11/08/2023

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S 169	Continued From page 1 a lever-style handle that could be locked or unlocked with the use of a key. Testing of that door handle at the same time of the observation revealed it was not locked and was not closing into the door frame. Further observation at the same time revealed the employee breakroom had an exit door to the exterior, testing of that door revealed no staff response to opening it. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. When asked if the door was alarmed, he stated he was unsure if that door was alarmed or if staff were just not responding.	S 169	Administrator or designee will audit preventative maintenance program documentation weekly times 90 days to ensure completion. Administrator or designee will audit 5 doors weekly times 90 days to ensure proper function. Audits will be reported to the QAPI Committee monthly for further analysis and recommendations, until such time that the QAPI Committee determines that compliance has been met and sustained	