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 ______	09/01/2022

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 8/29/22 through 9/1/22. Avantara Milbank was found not in compliance with the following requirement: F880.	F 000	**Directed Plan of Correction** **Avantara Milbank** **F880** **Corrective Action:** 1. For the identification of lack of: *Appropriate contact precaution posting for hand washing before, during, and following direct care for resident with C-diff. As well as use of other personal protective equipment (PPE). *Appropriate cleaning solution for housekeeping/cleaning in resident room and bathroom where there is C-diff. The administrator, DON, and/or designee reviewed the policies and procedures for the above identified areas. The medical director was not available for review at the time of plan of correction but had reviewed and approved the infection prevention and control policies prior to survey. No revisions were necessary as they are in line with CDC and CMS recommendations for the above identified areas. All facility staff who provide or are responsible for the above cares and services, including med ,	10/21/22
F 880 SS=E	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: §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	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 9/22/22

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.

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F 880 Continued From page 1

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 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:
A. Based on observation, interview, and policy review, the provider failed to correctly post and

F 880

aides C and G, housekeepers E and F, and LPN H will be educated/re-educated by 10/21/22 by the DON/Infection Preventionist or designee.

2. **Identification of Others:**
ALL residents and staff have the potential to be affected by lack of:
*Appropriate and accurate contact precaution posting.
*Appropriate cleaning solution for housekeeping/cleaning in resident room

Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 10/21/22 by the DON/Infection Preventionist or designee.

System Changes:

3. Root cause analysis conducted answered the 5 Whys: The root cause for the observed lapses in infection control practices at the time of survey was identified as: The appropriate precaution practices were not verified or communicated to staff by the DON/Infection Preventionist.

10/21/22

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F 880	Continued From page 2	F 880		

follow the provider's Clostridioides difficile (C. diff.) policy of contact precautions specific to cleaning a resident's (11) room by two of two housekeepers (E and F). Findings include:

1. Observation on 8/30/22 at 8:16 a.m. of an isolation cart outside of room resident 11's room revealed:
*He was on droplet precautions.
*Droplet precautions PPE (personal protective equipment) and hand hygiene required during and after cares included:
-Goggles, mask, gloves, and gown.
-Use of hand sanitizer or use of soap and water to wash hands.

Interview on 8/30/22 at 8:20 a.m. with medication aide (MA) C regarding isolation for resident 11 revealed:
*The resident was on precautions due to having C. diff.
-Correct isolation posting would have been contact precautions, not droplet precautions.

Observation and interview on 8/30/22 at 8:24 a.m. with MA C during medication pass revealed she:
*Had been wearing eye protection and an N-95 mask.
*Used hand sanitizer before entering resident 11's room.
*Entered his room without putting on gloves or a gown.
*Used hand sanitizer after exiting the room.
*Stated he was independent with his cares.
*She would have worn a gown, gloves, eye protection, and a face mask if she were to come into direct contact with resident 11.
*Resident 11 and the adjacent room shared a

Provider's Plan of Correction:

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. The DON/Infection Preventionist contacted the South Dakota Quality Improvement Organization (QIN) on 9/21/22. The root cause analysis and this plan of correction were discussed. The QIN agreed with the plan of correction and provided links for tools that may be used in continued staff education.

Completion date: 10/21/22

Monitoring:

4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained.

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F 880	Continued From page 3 bathroom. *Neither resident 18, who resided with resident 11, nor the residents in the adjacent room used the shared bathroom as they mainly used commodes or were incontinent most of the time. Interview on 8/30/22 at 8:35 a.m. with MA G regarding their PPE practices revealed: *Staff were supposed to put on a gown and gloves if they were to enter resident 11's room and change PPE in between resident cares. *Resident 11 was usually the only one that used the shared bathroom. 2. Observation and interview on 8/30/22 at 9:00 a.m. with housekeeper E regarding cleaning practices for residents with C. diff. revealed she: *Used the spray bottle of sanitizing solution with the label of "Sani-Clean 2" label on it. *The sanitizing solution in the spray bottle was actually "Micro-Kill Q3." -They would refill their spray bottles from a large bottle of Micro-Kill Q3. *She used "Non-acid toilet bowl cleaner" to clean resident's toilets. *A chemical labeled "Digester/eliminator of uric acid and organic soils" was used to clean urine and feces. *Had not been aware of what type of cleaning or disinfectant to use for C. diff. Review of the manufacturer's labels for "Micro-Kill Q3," "Non-acid toilet bowl cleaner," and "Digester/eliminator of uric acid and organic soils" revealed that none of them killed C. diff. spores. Interview on 8/30/22 at 9:08 a.m. with housekeeping supervisor F about usage of Micro-Kill Q3 chemical revealed:	F 880	Monitoring for determined approaches to ensure effective implementation and ongoing sustainment of staff compliance with: *Appropriate and accurate precaution posting. *Appropriate PPE use and hand hygiene. *Appropriate cleaning solution for housekeeping/cleaning of resident rooms. 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.	10/21/22

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*The current cleaner used would not kill C. diff.
*Bleach was needed to prevent the spread of C. diff.
*Was not aware that resident 11 was on contact precautions due to his C. diff. diagnosis.

Interview on 8/30/22 at 10:15 a.m. with housekeeper E regarding infection control training and practices while cleaning revealed:
*She was aware of contact precautions for resident 11.
*She worked at the facility for ten years and had not received any infection control training.
*She had been informed to wear gloves while cleaning resident 11's room due to precautions.

3. Interview on 8/30/22 at 10:44 a.m. and 3:50 p.m. and on 8/31/22 at 2:40 p.m. with DON B regarding observations and interviews relating to infection control revealed:
*Resident 11 had been diagnoses with C. diff. on 8/26/22.
*Resident 11 had been educated on the need for washing his hands with soap and water prior to leaving his room, and about staff wearing PPE while in his room.
*Resident 11 required regular reminders to wash his hands with soap and water.
*Staff only need to wear PPE if encountering fecal material.

B. Based on interview and policy review, the provider failed to ensure director of nursing (DON) (B) provided necessary and consistent education to all staff about caring for resident(s) that had been diagnosed with C. diff. Findings include:

1. Interview on 8/30/22 at 10:30 a.m. with

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housekeeping supervisor F about infection control training provided to staff revealed:
*She had been the housekeeping supervisor for one month although she had worked in the department for eight years.
*She had completed some webinars associated with the housekeeping supervisor position.
*Had been aware that bleach was needed to kill C. diff. spores.
*Staff received information from "Group Me" regarding new infection control precautions needed.
*Staff that had not received the "Group Me" notification would have received information verbally.
*There was no information regarding infection control precautions posted for staff to reference, other than the information on the PPE cart outside of resident 11's room.

2. Interview on 8/30/22 at 10:40 a.m. with licensed practical nurse (LPN) H regarding initiating contact precautions related to a diagnosis of C. diff. revealed:
*She had known that hand washing with soap and water is the only appropriate hand hygiene method while caring for anyone with C. diff.
*Stated that any staff member can initiate contact precautions and set up the isolation cart.
*She had not realized that droplet precaution information had been listed.
*Agreed that resident 11 had been the only one using the bathroom.
*He had been taught to wipe down the toilet after use.
-He had been provided with non-bleach disinfecting wipes.
*Staff instructed resident 11 to wash his hands with soap and water after using the toilet and

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before leaving his room.

3. Interview on 8/30/22 at 10:44 a.m. with DON B regarding observations and interviews relating to infection control revealed:
*She and another staff nurse had been sharing the role as infection preventionist.
*Had not been aware that the isolation precaution information identified droplet precautions, which still indicated hand sanitizer as an approved method of hand hygiene.
*Agreed that resident 11 should have been placed on contact precautions.
*Had not been able to find contact precautions signage that explained to use soap and water for hand hygiene.

4. Observation and interview on 8/31/22 at 10:36 a.m. with housekeeper E regarding C. diff. cleaning practices revealed she:
*Had cleaned "mostly" everything with bleach wipes.
*Placed a layer of bleach wipes on the floor, placed a rag on top of the bleach wipes, and used her foot to step on the rag and bleach wipes to clean the floors.
*After exiting resident 11's room, she removed her gloves and wiped her hands off on a wet rag that had been soaking in a bucket of non-bleach sanitizing solution. She then used hand sanitizer on her hands.
*She was not wearing a gown while cleaning resident 11's room.
*When asked if she knew what type of hand hygiene to perform after removing her gloves, she stated hand sanitizer.
*Surveyor encouraged use of soap and water as proper hand hygiene following cleaning a room with C. diff.

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Interview on 9/1/22 at 9:59 a.m. with DON B regarding education of staff for mixing bleach when cleaning rooms that had a resident with C. diff. revealed:
*Housekeeping should be mixing bleach with water and using it to clean any room with residents diagnosed with C. diff.
*She had spoken with housekeeping about using bleach to kill C. diff. spores.
-She clarified her conversation with housekeeping was specific to locating bleach for usage.
-She had not verified that housekeeping had been using bleach for cleaning.

Interview on 9/1/22 10:15 a.m. with administrator A regarding observations and interviews with staff, cleaning per facility policy for residents with C. diff. revealed he:
*Was aware of how to clean a room with bleach when a resident had C. diff.
*Was unaware that staff had not been using bleach.
*Had expected staff to follow facility policy for cleaning regarding C. diff.
*Stated this information had not been discussed during the stand-up meeting that morning.
*Agreed information regarding infection control practices and following policies should have been discussed and verified by the infection preventionist during the stand-up meetings to educate staff and ensure awareness.

Review of provider's December 2021 Transmission Based Precautions policy revealed:
*Contact precautions should be utilized for a resident with C. diff. diagnosis.
*PPE station and signage for PPE required for contact precautions being used would be placed

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F 880	Continued From page 8 outside of a resident's room. Review of provider's December 2021 Clostridioides difficile policy revealed: *Residents were able to leave their room under the following conditions: -Stools could be contained. -The resident was cooperative and had good hand hygiene. -The resident completed hand hygiene prior to exiting their room. -Their behaviors did not risk transmission. *Environmental cleaning: use 1:10 bleach-to-water ratio for disinfecting. -Room cleaning included: bathroom and all other high and low touch areas, must be cleaned daily.	F 880		

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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 8/29/22 through 9/1/22. Avantara Milbank was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 9/19/22

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	435009	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/31/2022

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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 8/31/22. 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 deficiencies identified at K211, K223, K325 and K353 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, testing, and interview, the provider failed to provide an accessible path to exit as required at one of six exit door locations (central activity room exit door). Findings include: 1. Observation on 8/31/22 at 9:15 a.m. revealed the sidewalk originating at the exit from the central activity room ended at a fence. No gate was provided at the sidewalk to allow access to the public way.	K 211	1) The gates around the facility were taken out on 9/15/22. 2) The gates were taken out so that residents and staff are able to evacuate the facility in case of a fire. Staff will be educated on 10/6/22 regarding the gates and the evacuation plan. 3) The facility will have monthly evacuation drills for 90 days and 2x's per year after that. Administrator or designee will monitor this process . The Administrator or designee will report to the QAPI committee 1x a month for 90 days.	10/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/23/22

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K 211	Continued From page 1 Interview at the time of the observation with the maintenance supervisor confirmed those conditions. A gate was available south of the sidewalk across the lawn, but not visible from the sidewalk. The gate was connected to the fire system, and had a punch code. However, the code was not displayed. The maintenance supervisor did not know the code. Failure to provide easy egress as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants.	K 211		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain three storage areas (COVID wing kitchen, COVID wing Boutique, and nutrition services storage and office) as required. Findings	K 223	1) a. On 9/21/22 the items in the Boutique was cleaned out and discarded to prevent any combustible items to be in the Boutique in case of a fire. The area is safe and free of combustibles. b. On 9/21/22 the items in the kitchen was cleaned out and discarded to prevent any combustible items if there was a fire to occur. The area is safe and free of combustibles. c. On 9/21/22 the items in the nutrition storage and office was cleaned and organized to prevent any combustibles if	10/21/22

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	08/31/2022

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 223	Continued From page 2 include: 1. Observation on 8/31/22 at 10:30 a.m. revealed the COVID wing "Boutique" was over 100 square feet and had large amounts of combustible items stored in it. The corridor door had been removed from the space. 2. Observation on 8/31/22 at 10:40 a.m. revealed the COVID wing kitchen was over 100 square feet and had large amounts of combustible items stored in it. The corridor door from that room did not have a door closer. 3. Observation on 8/31/22 at 11:00 a.m. revealed the nutrition services storage and office was over 100 square feet and had large amounts of combustible items stored in it. The corridor door from that room did not have a door closer. Interview with the maintenance supervisor at the time of the observation confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of each affected smoke compartment.	K 223	there was a fire to occur. The area is safe and free of combustibles. 2) The facility will not store combustible items in the boutique, kitchen or nutrition office. Rounds will be done daily to assure combustible items are not being stored in those areas. Staff will be educated on 10/6/22 regarding not putting storage in rooms and offices. 3) The facility will conduct 2 audits per week to ensure there are no combustibles being stored in those areas of the building. The Administrator or designee will monitor the process for 90 days. The Administrator or designee will report to the QAPI committee 1x a month for 90 days.	10/21/22
K 325 SS=E	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot	K 325		

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	435009	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/31/2022

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AVANTARA MILBANK	1103 SOUTH SECOND STREET MILBANK, SD 57252

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K 325	Continued From page 3 horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to safely store alcohol based hand rub (ABHR) in one room (electrical room shared by environmental services as a work area). Findings include: 1. Observation on 8/31/22 at 9:00 a.m. revealed the electrical room shared by environmental services as a work area had a combined total of 24 gallons of boxed ABHR stacked within three feet of two electrical panels. The electrical code does not allow storage within three feet of a panel, and the flammable liquids code does not allow over 10 gallons of alcohol in a single smoke compartment. Interview with the maintenance technician at the time of the observation confirmed that finding. The deficiency affected two of numerous	K 325	1) The 24 gallons of alcohol was removed from the electrical box on 8/31/22, to ensure no combustible items are stored 3 feet of an electrical box 2) Administrator will do daily rounds to ensure nothing combustible or non- combustible is stored in front of the electrical box. Staff will be educated on 10/6/22 regarding not putting items in front of an electrical box. There will be postings added to the electrical boxes with instructions to not place storage in front of the boxes. 3) The facility will make sure audits will be done to ensure items are not being stored within 3ft of the electrical box and will be monitored 2x's a week by the Administrator or designee for 90 days. The Administrator or designee will report to the QAPI committee 1x a month for 90 days.	10/21/22

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	435009	A. BUILDING **01 - MAIN BUILDING 01** B. WING	08/31/2022

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 325	Continued From page 4 requirements for ABHR use.	K 325		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _______________ b) Who provided system test _______________ c) Water system supply source _______________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (38 quick response heads were not tested or replaced after 20 years of use). Findings include: 1. Record review on 8/31/22 at 2:00 p.m. revealed thirty eight quick response heads were listed as needing to be tested or replaced due to passage of time since installation. Further review revealed the same deficiency had been noted in the annual sprinkler contract maintenance in 2021 and in 2020.	K 353	1) Western States Fire Sprinkler Protection was contacted on 9/20/22 to replace the 38 automated sprinkler heads. 2) The facility will be in compliance when these 38 automated sprinkler heads are replaced. Estimated completion date to have the fire sprinklers replaced is 10/16/22 pending vendor availability. 3) The Administrator or designee will report to the QAPI committee 1x a month for 90 days.	10/21/22

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	435009	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/31/2022

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 353	Continued From page 5 Interview with maintenance supervisor at the time of the record review confirmed that condition had not yet been corrected. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353		

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 ______	09/01/2022

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 8/29/22 through 9/1/22. Avantara Milbank was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature]

TITLE Administrator

(X6) DATE 9/19/22