

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Avantara Milbank		STREET ADDRESS, CITY, STATE, ZIP CODE 1103 South Second Street Milbank, SD 57252	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>45383</p> <p>Based on observation, interview, record review, resident council review, and policy review, the provider failed to ensure prompt response to call lights and necessary care and services were provided for six of six residents (5, 8, 9, 15, 23, and 285) and one of six additional resident council meeting residents (18) to maintain their physical, mental, and emotional well-being. Those residents expressed frustration related to the delay in staff response to their call lights and requests for assistance. Findings include:</p> <p>1. Observation and interview on 3/11/25 at 12:25 p.m. with resident 5 in her room regarding call light response times revealed:</p> <p>*Sometimes it would have taken staff an hour to answer her call light and it had frustrated her.</p> <p>*Resident 5's daughter stated she had witnessed 30-45 minutes.</p> <p>50915</p> <p>2. Interview on 3/11/25 at 1:00 p.m. with resident 285 revealed:</p> <p>*Staff would take a long time to answer call lights, especially around meal times.</p> <p>*Sometimes it would take staff 20 to 30 minutes for staff to answer her call light.</p> <p>*She felt they were short on staff who could help residents sometimes.</p> <p>3. Interview on 3/11/25 at 1:05 p.m. with resident 8 revealed she felt staff took a long time to answer her call light.</p> <p>4. Interview on 3/11/25 at 3:19 p.m. with resident 15 revealed:</p> <p>*He said staff wanted him to use his call light for assistance.</p> <p>-When he used it, he felt it took them a long time to answer it.</p> <p>-He has fallen in the past.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-This was frustrating to him.</p> <p>*He stated he had witnessed CNAs gathered at the nurses' station ignoring call lights.</p> <p>5. Interview on 3/12/25 at 2:30 with resident 23 revealed:</p> <p>*Call light response wait times were very long, sometimes as long as one hour.</p> <p>*Resident 23 said, When I have to go to the bathroom, I don't have an hour [to wait for help].</p> <p>-This was frustrating to the resident.</p> <p>6. Interview on 3/12/25 at 10:40 a.m. with licensed practical nurse (LPN) I revealed:</p> <p>*The facility had a new call light system, less than six months old.</p> <p>-There was a central monitor at the nurse's station that showed activated call lights until they were answered.</p> <p>*All caregiver staff (such as certified nursing assistants (CNAs) and nurses) carried a pager to notify them when a call light was activated.</p> <p>*The pager would remind them of an activated call light at five-minute intervals until the call light was answered.</p> <p>*The facilities' process was nurses usually would not answer call lights until after the first five minutes had passed.</p> <p>*She expected staff to answer residents' call lights within ten minutes.</p> <p>7. Interview on 3/12/25 at 11:20 a.m. with registered nurse (RN) G revealed:</p> <p>*She did not feel staff time for answering call lights was an issue.</p> <p>*She expected staff to answer residents' call lights within five to ten minutes.</p> <p>*She felt a wait longer than 15 minutes was unacceptable.</p> <p>8. Interview on 3/12/25 at 11:30 with CNA E revealed:</p> <p>*The provider's expectation to answer call lights was five minutes.</p> <p>*That was regularly reminded to staff during daily huddles (a team meeting daily to give staff updates).</p> <p>9. Review of call light logs for resident 285 revealed:</p> <p>*She had pressed her call light 44 times between 2/10/25 and 3/1/25.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>13. Review of call light logs for resident 5 revealed:</p> <ul style="list-style-type: none"> *She had pressed her call light six times between 2/10/25 and 3/1/25. *Three times the response time was over ten minutes. *One time the response time was over 20 minutes. <p>14. Review of the provider's 2/25/25 resident council (a meeting where residents can discuss concerns with staff) minutes revealed:</p> <ul style="list-style-type: none"> *Three of the six residents in attendance shared the concern that their call lights were not being answered timely. -Specifically, during morning hours, medication passes, and at bedtime. *Call light audits from 2/28/25 revealed: -One call light was answered in seven minutes. -Six call lights were answered in less than five minutes. <p>15. Review of provider's 2/7/25, 2/10/25, and 2/11/25 Daily Shift Huddle sheet revealed:</p> <ul style="list-style-type: none"> *Expectation for call light is to respond within 5 minutes. <p>16. Review of the provider's 3/3/25 daily shift huddle sheet revealed:</p> <ul style="list-style-type: none"> *2. Call bells [call lights] concern-remember to answer promptly. <p>17. Interview on 3/12/25 at 12:20 p.m. with interim director of nursing (IDON) B revealed:</p> <ul style="list-style-type: none"> *She expected staff to answer residents' call lights as soon as possible, and stated within five to ten minutes was reasonable. *She said taking longer than 15 to 20 minutes to answer call lights was unacceptable. <p>18. Review of the provider's 9/30/24 call lights policy revealed:</p> <ul style="list-style-type: none"> *Policy-It is the policy of the facility to ensure that there is prompt response to the resident's call for assistance. *Procedures 1. Facility shall answer call light in a timely manner. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that staff member will be back to assist them shortly. 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45383</p> <p>Based on observation, interview, and policy review, the provider failed to follow acceptable food service standards and their policies to ensure one of one kitchen was maintained in a clean and sanitary condition, and proper glove use by cook/dietary aide (J) while preparing and serving residents' food during one observed meal service. Findings include:</p> <p>1. Observation on 3/11/25 at 5:05 p.m. of serving pans under the steam table in the kitchen revealed:</p> <ul style="list-style-type: none"> *Food debris and a yellow film on some of the serving pans. *Food debris and a yellow film on three of the pan lids. *Food spatter and a yellow film on the side windows of the steam table. *Food spatter on the undersurface of the top of the steam table where plate covers had been located. <p>2. Observation on 3/11/25 at 5:15 p.m. of the storage racks next to the stove in the kitchen revealed:</p> <ul style="list-style-type: none"> *A moderate amount of dust was hanging from the first three racks. *One knife was on the floor under the storage rack. <p>3. Observation on 3/11/25 at 5:20 p.m. of cook/dietary aide J while serving food revealed:</p> <ul style="list-style-type: none"> *With his gloved hands he: <ul style="list-style-type: none"> -Retrieved buttered bread from a bowl and placed it on the resident's plate. -Retrieved a plate from the warming cabinet. -Dished beets and tuna noodle hotdish onto a plate. -Touched a resident's menu slip. -Repeated that same entire process for another resident. *He then removed his gloves, washed his hands, and put on a new pair of gloves. With those gloved hands he: <ul style="list-style-type: none"> -Retrieved coleslaw from the refrigerator. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*Wearing gloves to open the refrigerator door and then touching food items and touching resident's menu slips was not an acceptable food service practice.</p> <p>7. Interview and observation on 3/12/25 at 2:30 p.m. with administrator A in the kitchen revealed:</p> <p>*Dietary manager D had been sweeping the kitchen floor.</p> <p>*She agreed that there was an observable yellow residue on the convection oven and the steam table.</p> <p>8. Interview on 3/13/25 at 8:30 a.m. with administrator A regarding dietary manager certification revealed:</p> <p>*Dietary manager D was taking classes for her dietary manager certification.</p> <p>*The facility did not have a certified dietary manager.</p> <p>Review of the provider's April 2020 handwashing and glove use policy revealed:</p> <p>*Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food.</p> <p>*When gloves are used, handwashing must occur prior to putting on gloves and whenever gloves are changed.</p> <p>*It is important to remember that gloves can often give a false sense of security and can carry germs the same as our hands.</p> <p>Review of the provider's August 2018 Tray Carts, Dish Carts, Utility Carts policy revealed:</p> <p>*Wash inside (sides, top, bottom, tray guides, and inside of door). Use sanitizing solution and clean cloth.</p> <p>*Rinse with clean, warm water and clean cloth.</p> <p>*Allow to air dry.</p> <p>*Frequency: Weekly.</p>		