STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure one of one resident (1) had a physician's order for supplemental oxygen when she was readmitted to the facility, and was provided continuous oxygen using a nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) by the staff. Findings include:Based on observation, interview, record review, and policy review, the provider failed to ensure one of one resident (1) had a physician's order for supplemental oxygen when she was readmitted to the facility and was provided continuous oxygen using a nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) by the staff.Findings include: 1. Observation and interview on 2/11/26 at 10:41 a.m. with resident 1 in her room revealed there was an oxygen concentrator (a device that filters room air into purified oxygen). Attached to the concentrator was an NC tube and a plastic bottle that contained water (a bubbler), which was used to humidify the oxygen inside it. There was no date on the bubbler or the NC tubing to indicate when they were provided or cleaned. There was no sign outside of the resident's room to indicate that oxygen was in use. Resident 1 indicated she propelled herself to her room after she had breakfast in the dining room, and she did not start the oxygen concentrator or put on the NC tubing when she returned. She stated she knew that she was to receive the oxygen and wear the NC tubing per her doctor's order. Resident 1 attached the NC tubing around her ears, placed the nasal prongs on the tubing in her nose, and turned on the oxygen concentrator. Observation and interview on 2/11/26 at 11:00 a.m. in resident 1's room revealed that resident 1 did not have the NC tubing on, and the oxygen concentrator was not on. Still, shortly after I had entered her room, she stated, I better put this on like I am supposed to (NC tubing) and applied the NC tubing. She then turned on the oxygen concentrator, which revealed the settings were set to 1.3 L/min. The resident was short of breath during our interview and stated, I am short of breath because I just brought myself back to my room from the dining room. Licensed practical nurse (LPN) G entered resident 1's room and checked her oxygen saturation level with a pulse oximeter (a finger-clipped device that measures blood oxygen saturation and pulse). The amount of oxygen resident 1 was to receive using the NC was contingent upon her oxygen saturation level, which was 98 percent, and she did not remove the NC tubing or shut off the concentrator. 2. Observation of the certified nurse assistant (CNA) B pocket care plan (a document that identifies residents' care needs and interventions) revealed that resident 1 was to have Oxygen at all times. 3. Interview on 2/18/26 at 9:34 a.m. with ward secretary (WS) V revealed that resident 1 did not have a physician's order for oxygen using an NC at 1 percent L/min if her oxygen saturation level was less than 90 percent, to change the oxygen tubing, or to have the bubbler cleaned. 4. Interview on 2/18/26 at 9:52 a.m. with LPN D revealed that the CNAs will ask the nurse what the resident's oxygen concentrator should be set to when they turn the concentrator on and apply the NC tubing for residents. 5. Interview and record review on 2/18/26 at 12:25 p.m. with LPN F revealed that resident 1 was (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the hospital on [DATE], and was discharged from the hospital and readmitted to the facility on [DATE]. When she was readmitted to the facility, there was no physician's order written for oxygen to be administered using a NC if the resident's oxygen saturation level was less than 90 percent. 6. Interview on 2/18/26 at 9:39 a.m. with CNA GG revealed she was not aware of resident 1's physician's order for oxygen, and it was not on the CNA pocket care plan on how to care for the residents. She indicated that she only knew resident 1 was to have her NC on. 7. Interview on 2/18/26 at 3:09 p.m. with director of nursing (DON)/infection preventionist B revealed that resident 1 should have had a physician order in her electronic medical record (EMR) for oxygen to be applied using a NC at 1 L/min if her oxygen saturation level was less than 90 percent. Resident 1 should have treatments to be completed by the staff listed on her treatment administration record (TAR) for the bubbler to be cleaned weekly, for the NC tubing to be changed twice per month, and for a sign to be placed outside of her room to indicate oxygen was in use. 8. Review of resident 1's EMR revealed her 1/13/26 Brief Interview for Mental Status (BIMS) was 15, which indicated she was cognitively intact. She had a diagnosis of heart failure. There was a respiratory treatment order in resident 1's TAR to check her oxygen saturation level three times a day, morning, evening, and at night. The order indicated that if her oxygen saturation level was greater than 90 percent, she did not need supplemental oxygen. There was no physician order for oxygen to be supplied using a NC at one percent L/min if her oxygen level was less than 90 percent. There was no order to change the NC tubing or clean the bubbler. 9. Review of the provider's revised 10/19/26 Oxygen Therapy policy revealed, Place sign OXYGEN IN USE outside the room of the resident. Cleanse humidifier/bubbler on a weekly basis. Reservoirs must be kept dry when not in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to incorporate one of one sampled resident's (9) Level II (2) Preadmission Screening and Resident Review (PASRR) into the Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment.Findings Include:1. Review of resident 9's electronic medical record (EMR) revealed she had a diagnosis of post-traumatic stress disorder (PTSD) and she was admitted to the facility on [DATE]. Her 11/11/25 MDS comprehensive assessment and 1/28/26 MDS quarterly assessment indicated that a PASRR Level II was not completed.2. Interview on 2/18/26 at 2:30 p.m. with social worker (SW) J revealed that the facility did not have a process to update the staff on if a PASRR Level II was completed for a resident. She completed the PASRR forms and kept them in her office. She did not share the completed PASRR documentation with the interdisciplinary team or registered nurse (RN)/MDS coordinator C. SW J stated, It would never occur to me that I would have to tell [RN/MDS coordinator C] if the resident was a PASRR Level I or II. I would let the nursing team know what the recommendations were, if any, from the PASRR. I don't have permissions other than Section S [state defined items] on the MDS to update anything.3. Review of resident 9's PASRR Level II obtained from SW J revealed she was reviewed by the South Dakota's contracted PASRR service on 10/27/25 and was approved for a 180 day stay at the facility with an end date of 4/25/26.4. Interview on 2/18/26 at 3:25 p.m. with RN/MDS coordinator C revealed there was no process to determine whether a PASRR Level II was completed for a resident and that Section S of the MDS assessment does not trigger Section A (the section for the resident's identifying information). RN/MDS coordinator C was not aware that SW J completed a PASRR Level II for the residents.5. Review of the provider's July 2025 admission Process - Criteria policy revealed The resident must meet the following medical/psychosocial and financial criteria to be eligible for admission: Must have PASRR pre-admission screening and approval for appropriate level of care prior to admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. A. Based on observation and interview the provider failed to ensure one of one sampled resident (32) had anything to eat or drink or had blood glucose monitoring within thirty minutes of receiving Novolog (a fast-acting insulin used to lower blood sugar) administered by licensed practical nurse (LPN) D. Findings include:1. Observation and interview on 2/12/26 at 7:51 a.m. of LPN D revealed: *She woke up resident 32 to administer her insulin. The resident had not eaten breakfast yet but was going to get a room tray. *Resident 32's blood sugar was 264 (normal blood sugars are 70-130), and LPN D administered 5 units of Novolog and 42 units of Toujeo SoloStar (a long-acting insulin). 2. Observation on 2/12/26 at 8:53 a.m. revealed resident 32 was sleeping, her room tray was delivered and left on her bedside table by CNA GG. 3. Interview on 2/12/26 at 9:17 a.m. with resident 32 revealed that the staff did not wake her up when they delivered her room tray, and she did not eat anything yet that day. 4. Observation on 2/12/26 at 9:22 a.m. revealed resident 32 was sleeping, and her breakfast tray sat on her bedside table untouched. 5. Interview on 2/12/26 at 9:24 a.m. with LPN D revealed: *After Novolog was administered, the resident should have something to eat or drink within 20 to 30 minutes because it was a fast-acting insulin. *The staff were to wake resident 32 up to eat and set up her room tray. *She went into resident 32's room, woke her up, set her tray up, and encouraged her to eat her food. 6. Interview on 2/12/26 at 9:35 a.m. with certified nursing assistant (CNA) GG revealed: *She had delivered the room tray to resident 32. *She was to wake the residents up when she dropped their room trays off, set the room tray up if they needed her to, and feed the residents if they could not feed themselves. *Resident 32 was able to feed herself but needed her room tray set up. 7. Interview on 2/12/26 at 10:07 a.m. with pharmacist Q revealed that after administering Novolog to a resident, the resident should have something to eat or have blood glucose monitoring completed within 30 minutes. 8. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed that after Novolog was administered to a resident, the resident should eat within 20 to 30 minutes. The provider did not have an insulin administration policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (42) had a physician's order for compression stockings in her electronic medical record (EMR) and on her treatment administration record (TAR). 1. Observation and interview on 2/10/26 at 4:23 p.m. with resident 42 in her room revealed she had bilateral compression stockings on each of her lower legs. She indicated the staff would put them on her every morning when they put her clothes on. She stated the stockings helped with the swelling in her lower legs, but was unsure what caused it. Interview on 2/12/26 at 11:07 a.m. with CNA H revealed that resident 42 was to wear her bilateral compression stockings when out of bed to assist with the edema in both lower legs. Interview on 2/18/26 at 1:30 p.m. with resident 42 revealed she did not have bilateral compression stockings on her lower legs. She indicated that the compression stockings were in the bathroom, and the staff did not put them on her when they dressed her that morning. Interview on 2/18/26 at 12:25 p.m. with LPN F verified that resident 42 did not have an active physician's order for the bilateral compression stockings, and she should have. Interview on 2/19/26 at 3:09 p.m. with the director of nursing, A revealed that resident 42 should have had a physician's order for the compression stockings in EMR. She should have had a treatment listed on her TAR for the compression stockings to be applied by the staff in the a.m. and taken off in the p.m. Observation of the Team 1 CNA B pocket care plan revealed that resident 42 was to have Ace wraps on/am and off/HS (bedtime). 2. Review of resident 42's electronic medical record (EMR) revealed her 2/11/25 Brief Interview for Mental Status (BIMS) was 15, which indicated she was cognitively intact. She had a diagnosis of atherosclerotic heart disease of native coronary artery (plaque buildup in the heart's natural arteries), and a cerebral infarction due to an embolism of the left anterior cerebral artery (uncommon ischemic stroke). She had a 11/22/21 physician's order to apply TED (Thrombo-Embolism-Deterrent hose that prevents blood clots) hose (knee high) to both lower extremities in the a.m. and off in the p.m. She had a 6/7/22, physician's order for an Ace elastic bandage to both lower extremities daily, on in the a.m. and off in the p.m. On 8/22/23, the Ace elastic bandages were discontinued. She had a 10/21/25 physician's order to hold the compression stockings and measure both ankles daily in the a.m. starting on 10/22/25 through 10/25/25. She had a 10/27/25 physician's order to discontinue the compression stockings due to no changes in the ankle measurements. Her primary care provider assessed her on 12/15/25, and the progress note indicated Her weight remained unchanged. She lasted one day right after my last visit without her compression stockings on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her lower extremities. There was no physician order initiated on 12/15/25 that indicated resident 42 is to wear bilateral compression stockings. The facility did not have a policy regarding physician orders being transcribed and communicated to the designated staff to be implemented for the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record review, and policy review, the provider failed to implement pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) prevention interventions for one of one sampled resident (3) who was identified at risk for developing a pressure ulcer and developed an unstageable (wound bed not visible due to covering, such as debris, dead tissue, scabbing, or a non-removable dressing) pressure ulcer to her left heel while under their care. Findings include:1. Observation on 2/10/26 at 10:57 a.m. of resident 3 in the dining room revealed that she was sitting upright in her wheelchair. She was not wearing heel boots (a cushioned boot used to reduce pressure from a person's heel. 2. Observation on 2/10/26 at 2:21 p.m. of resident 3 in her room revealed she was still sitting in her wheelchair without heel boots on. That had been over approximately three hours she remained in the same position. 3. Review of resident 3's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) revealed a focus area documented on 12/9/25 that indicated I have a skin injury and chronic fragile skin because I can't move around on my own. I have multiple sclerosis (MS) [a chronic autoimmune disease of the central nervous system where the immune system attacks the nerves in the brain, leading to communication issues between the brain and body], and I am confined to a bed or chair (non-ambulatory), I show this by having an existing skin injury (unstageable, pressure injury to left heel), my Braden's [a tool used to assess the risk of developing pressure ulcers] indicate a risk. I need my aides to help me reposition at least every one hour when I'm in a chair and every two hours during the night while I am in bed. Use pressure-reducing devices: air mattress in bed and cushion in wheelchair and recliner, heel boots to the left foot as needed. There was a 2/10/26 physician's order to cleanse left heel open area with normal saline (NS) and soap then apply therapeutic moisturizing fragrance free creme (due to dryness) twice a day. Another 8/2/22 physician's order indicated the heel boots should be placed on the resident's feet every morning, afternoon, and during the night shifts. Review of resident 3's electronic medical record (EMR) revealed that her Braden assessment scores ranged from 16 to 17, which indicated she had a mild risk for developing pressure ulcers. Her 12/11/25 Brief Interview for Mental Status (BIMS) score was 11 which indicated her cognition was moderately impaired. Review of resident 3's EMR revealed on 7/8/25 there was documentation for a new or sudden onset of left lower leg edema and blister to her left heel. The wound developed into an unstageable pressure ulcer. On 12/22/25 wound measurements revealed 4.0 centimeters (cm) long by 3.0 cm wide. On 2/16/26, the wound measurements were 2.0 cm long by 2.8 cm wide, and 0.1 cm deep. 4. Interview on 2/10/26 at 3:25 p.m. with resident 3 revealed that she did not have any complaints about her cares and she did not have any complaints of pain when the staff were completing her wound care. 5. Interview on 2/10/26 at 4:50 p.m. with licensed practical nurse (LPN) G revealed that resident 3 had an open skin wound on the back of her left heel. She explained that the wound nurse, LPN D, instructed the staff to leave the area open to air (a treatment method where wounds are left uncovered, without bandages or dressings, after initial cleaning) and to use a heel boot for cushioning to prevent it from getting bumped. 6. Observation on 2/11/26 at 8:41 a.m. of resident 3 in her room revealed she was asleep in her wheelchair with no heel boot on her left foot. She was wearing nonskid socks and no shoes. 7. Observation on 2/11/26 at 12:18 p.m. of resident 3 in her room revealed she was sitting in her wheelchair with no heel boot on her left foot. She was wearing nonskid socks and no shoes. 8. Observation on 2/11/26 at 4:37 p.m. of resident 3 in her room revealed that she was sleeping in a recliner. She was wearing a heel boot on her left foot. Director of nursing (DON) B and LPN D entered the resident's room to perform wound care. During the wound care treatment, resident 3 reported no pain in the area. LPN D stated they were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	leaving the wound open to air due to dry, sloughing skin (dead skin tissue in a wound that slows healing) around the wound. After the wound care was completed, DON B and LPN D did not reapply the left heel boot. Interview at that time with DON B and LPN D revealed that resident 3's pressure ulcer started out as a blister in July 2025 when they were using ACE wraps to try to control the edema (swelling caused by too much fluid trapped in tissues) in her legs. The clinic wound care nurse advised them that the ACE wraps would have to be removed and reapplied about eight times per day to treat the edema. Staff could not keep up with removing and reapplying the ACE wraps that many times per day, which resulted in the blister forming and opening. LPN D stated that wound care was completed once daily and wound assessment with measurements were completed weekly. 9. Observation on 2/12/26 at 8:45 a.m. in resident 3's room revealed that resident 3 did not have a heel boot on her left heel. She was sitting in her wheelchair and was leaning to the left side with her heel resting on the wheelchair footplate. 10. Interview on 2/12/26 at 9:29 a.m. with medication aide (MA) S revealed she was expected to reposition her assigned residents every two hours. She stated that the CNA Sheets have the information about each resident and their care needs. 11. Observation on 02/18/2026 at 2:03 p.m. of resident 3 in her room revealed she was lying on her back in bed without heel boots or pillows to offload pressure from her heels off the mattress. 12. Observation on 2/18/26 at 4:35 p.m. of resident 3 in her room revealed she was in the same position as the above observation. She had been lying in that same position for approximately 2 hours and 30 minutes. 13. Interview on 2/19/26 at 9:49 a.m. with certified nursing assistant (CNA) DD revealed that she used the CNA sheet (a document that identifies residents' care needs and interventions) to know how often to reposition the residents. She said that for resident 3, she usually laid her down after meals. CNA DD explained that she helped resident 3 put the heel boots on only when the resident was in her wheelchair, but not when the resident was in bed. She said she did not understand why resident 3 would need the heel boots on in the bed or the recliner, so she did not apply the heel boots in those situations. 14. Interview on 2/19/26 at 9:57 a.m. with CNA H revealed that she was not aware of resident 3's specific care needs, but she would refer to the CNA sheets for specific resident care needs such as turning and repositioning and use of pressure relieving devices. 15. Interview on 2/19/26 at 10:05 a.m. with CNA collaborator W revealed that she would refer to the CNA sheets for specific resident care needs. If the travel staff were not aware of how to care for a resident she would locate a nurse on duty. 16. Review of the CNA sheet revealed that it did not include information regarding resident 3's pressure ulcer interventions to her left heel, including when to reposition her or to use her heel boots. It indicated the staff should monitor her skin for breakdown, lay her down after her meals, use an air mattress on her bed, and place a cushion in her chair. 17. Interview on 2/19/26 at 1:34 p.m. with DON B revealed that she confirmed that resident 3's pressure ulcer on her left heel developed because of the use of ACE wraps for edema. She reported that the wound assessments were completed weekly on resident 3 and the Braden assessments were completed quarterly. She said that residents should ideally be repositioned every two hours unless resident 3 requested otherwise. When asked about resident 3's care plan, which directed the staff to reposition her every one hour, DON B responded, well that is not happening with anyone. She agreed that the care plan should reflect the most current care that a resident needed to achieve the highest level of health and safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure medications were securely stored and labeled for safe use according to professional standards to ensure:*One of one medication room was free from expired medical supplies.*Insulin pens for three of six sampled residents (7,12, and 32) were dated when removed from the refrigerator.*Five of five sampled residents (7,9,35,46, and 48) inhalers were dated when opened.*Two of two glucose test strip bottles were dated when opened.*Two of two medication carts were locked when unattended by two of two nurses (B and R). Findings include:1. Observation and interview on [DATE] at 10:20 a.m. in the medication room with licensed practical nurse (LPN)/director of nursing (DON) in training E revealed: *There was a sign that hung on the refrigerator that stored insulin to indicate how long different types of insulins were good for once opened. *There were thirteen swabs that tested for respiratory infections that expired on [DATE]. *There was one wound culture that expired on [DATE]. *There were two urinary catheter drainage bags that expired on [DATE] and [DATE] *There were three 14 french (fr) self cath (flexible tubing placed in the bladder to drain urine and then removed) kits that expired on [DATE] and [DATE]. *There were sixteen 14 fr female straight catheters that expired on [DATE]. *The code (medical emergency) box contained one suction yanker (suction instrument) that expired on [DATE], four nasopharyngeal airways (emergency airway) that expired [DATE], [DATE], and [DATE], two endotracheal tube (ETT) (emergency airway) that expired on [DATE] and [DATE], one non-rebreather mask (for oxygen administration) that expired on [DATE], and one nasal cannula tubing (for oxygen administration) that expired on [DATE]. *They used the code box yesterday on a resident. *The overnight nurses were to check the outdates in the medication room on their downtime, and medication aide (MA) S checked the outdates weekly. *LPN/DON in training E verified that the expired items should have been removed, and if expired items were used, they could not ensure that the item would function appropriately and could not guarantee sterility. 2. Observation and interview on [DATE] at 4:25 p.m. with LPN/DON in training E of the [NAME]/Humming Bird medication cart revealed: *Resident 35 had fluticasone and albuterol inhalers that were opened, used, and not dated. *Resident 7 had a used Amelog Solos Star insulin pen that expired on [DATE], a used Lantus insulin (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pen that was not dated, and an albuterol inhaler that was opened, used, and not dated. *There was one bottle of glucose test strips that was open and not dated to indicate when it had been opened. 3. Observation and interview on [DATE] at 4:30 p.m. with LPN/DON in training E of the Farmer/Woodland medication cart revealed: *Resident 48 had an Alvesco inhaler that was opened, used, and not dated. *Resident 12 had a Lantus pen that was not dated once removed from the refrigerator. *Resident 32 had a Toujeo Solostar insulin pen that was opened, used, and not dated. *Resident 9 had a Trelegy Ellipta inhaler that was opened, used, and not dated. *Resident 46 had an albuterol inhaler that was opened, used, and not dated. *There was one bottle of glucose test strips that was opened and not dated to indicate when it had been opened. *LPN/DON in training E expected the insulin pens not to be used past the expiration date as it might not be as effective, and the insulin pens and inhalers to be dated once opened. The medication carts were to be checked for outdated items weekly by MA S and by the night nurses during their downtime. 4. Observation on [DATE] at 7:54 p.m. revealed a medication cart was in the hallway by resident rooms, it was not locked, and there were no staff present near it. Registered nurse (RN) R verified it was unlocked, and she thought it was okay to leave it unlocked since she was in a resident room that was across the hall from it. 5. Observation on [DATE] at 7:56 p.m. revealed one of the medication carts was left unlocked and unattended near a resident room with a resident sitting in front of the cart. DON B was then observed walking down the hallways towards the medication cart to continue passing medications. 6. Interview on [DATE] at 8:04 p.m. with DON B revealed she did not think the insulin pens needed to be dated until they were used, and not when they were taken out of the fridge. 7. Interview on [DATE] at 10:07 a.m. with Pharmacist Q revealed that insulin was to be dated once it was removed from the fridge. 8. Interview on [DATE] at 12:55 p.m. with DON B revealed that it was best practice to date insulin once it was removed from the fridge, inhalers were to be dated once opened, and the medication carts were to be locked when out of the nurse's vision. Regarding medication and supplies, they only had the Administration of Medication policy. 9. According to the provider's [DATE] Administration of Medication policy revealed: *It is best practice to lock cart prior to walking away from it, but at least visual control of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cart must be maintained to assure hat [that] no one else is able to access it. *The medication cart is to remain locked at all times when a nurse is not in close proximity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interview, and record review, the provider failed to ensure two of two dietary staff (cook L and dietary aide P) followed the menu serving sizes for each diet offered for two of two observed meals. This had the potential to affect all residents who requested the main menu items. Findings Include:1. Observation on 2/10/26 at 11:25 a.m. in the kitchen revealed that cook L was preparing to set up the hot-serving table for the lunchtime meal service. Interview at that time with cook L revealed that most residents requested smaller portions, but she provided about four ounces of the meat option and two ounces of vegetables or two ounces of the side dish to the residents. She did not reference the dietitian?approved menu at that time to verify the correct serving sizes for each prescribed resident diet.2. Observation on 2/10/26 from 11:50 a.m. to 12:19 p.m. in the dining room during lunch revealed that cook L was placing serving utensils in the food items. She used a four-ounce scoop for the peas, and two-ounce scoops for the pureed peas, stewed tomatoes, and mashed potatoes. When serving the stewed tomatoes, mashed potatoes, and pureed peas, cook L only used one scoop, meaning that only two ounces were served. [NAME] L served smaller portions of the baked chicken legs to the female residents, and she served the larger bone-in chicken breasts to the male residents. Additionally, cook L was serving residents one scoop (about two ounces) of mashed potatoes, and one scoop (about two ounces) of the pureed peas to residents. The menu indicated four ounces of mashed potatoes, and four ounces of peas should have been served.Cook L served resident 26 one scoop of peas (about four ounces), one scoop of mashed potatoes (about two ounces), one scoop of gravy (about two ounces), one slice of bread, and one small chicken leg. The laminated diet card did not indicate any requests for small-portioned meals.3. Review of the dietary extension menus revealed the menu for 2/10/26 included three ounces of protein (either the baked chicken or the cube steak), a half-cup of mashed potatoes (four ounces), and choice of a half-cup of stewed tomatoes or a half cup of peas. Residents on the pureed diet were supposed to have received a half-cup of the pureed peas. There was no small portions diet.4. Review of the resident diet orders report revealed that seven residents requested small portions, and two residents were on a pureed diet.5. Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed she expected staff to use the menu book that outlined the appropriate serving sizes for each menu item. There was a binder labeled Cold Orders in the kitchen for staff to access that contained all the menus and serving sizes for each diet. She expected all dietary staff to know where to find the diet menu spreadsheets and how to use them.6. Observation and interview on 2/18/26 at 11:51 a.m. with dietary aide P in the dining room revealed that she was using a two-ounce scoop for the mashed potatoes and ground beef. She said that cook L helped her set up the hot-holding table because she just started her job about four days ago. She used only one scoop of mashed potatoes and one scoop of the ground beef to serve the resident's their lunch.7. Review of the provider's menu for lunch on 2/18/26 revealed that the menu included a half-cup of mashed potatoes (about four ounces) and three ounces of roast beef (three ounces of ground beef for those on the mechanical soft diet).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to:*Minimize cross-contamination via glove use during two of three meals observed by cook L and during food preparation by dietary aide T.*Properly store and sanitize food thermometers prior to use by cook L.*Maintain one of one kitchen in a clean and sanitary manner as evidenced by dusty ceiling vents throughout the kitchen, dusty ventilation fans in one of one walk-in cooler, rusty shelves in one of one walk-in cooler, and food scum buildup inside one of one commercial dishwashing machine.*Monitor and document the temperatures for one of one commercial dishwashing machine according to the provider's policy to ensure it reached the minimum rinse cycle temperature of 180 degrees for sanitization of dishes and equipment used to prepare and serve residents' meals.*Ensure safe food storage practices were maintained as evidenced by storing potentially hazardous foods at room temperature for an extended period of time by one of one cook (L) and storing raw bacon above ready-to-eat (RTE) mashed potatoes in one of one walk-in cooler.*Discard visibly spoiled and expired foods on or before the manufacturer's date.Findings Include:1. Observation on 2/10/26 at 8:40 a.m. in the dining room revealed cook L was serving breakfast. She had on a pair of disposable gloves. She wore the same gloves throughout the observation. She touched several surfaces with those gloves, including the serving utensils, the laminated diet tickets, the serving table, her apron, and the handle of the serving cart. With those potentially contaminated gloves, she touched the food-contact surface of the plates and the slices of toast. She then used her gloved hand to scoop loose brown sugar into two-ounce plastic containers to serve with the hot cereal. She did not use a serving utensil for the toast or the brown sugar.Observation on 2/10/26 at 8:48 p.m. in the kitchen of dietary aide T revealed she was preparing cold deli sandwiches with disposable gloves on her hands. She touched several surfaces with those gloves including the loaf of bread, the sandwich meat, the plastic cling wrap, and the permanent marker to mark the date on the cling wrap. She then exited the kitchen to place the deli sandwiches in the refrigerator in the cafeteria. She came back to her prep area and continued making sandwiches without changing gloves or performing hand hygiene.Interview on 2/10/26 at 8:52 a.m. with dietary aide T about the above observation revealed she prepared those deli sandwiches for both staff and residents. She wrapped the sandwiches in cling wrap and wrote the preparation date on the cling wrap using the permanent marker.Observation on 2/10/26 at 11:55 a.m. during lunch service in the dining room revealed cook L wore a pair of disposable gloves. She touched the serving utensils, the serving table, and the laminated diet cards. With those potentially contaminated gloves, she touched the food-contact surface of the plates and slices of bread.Continued observation on 2/10/26 at 11:58 a.m. during lunch service in the dining room revealed dietary aide M wore a pair of disposable gloves. He touched the serving table and the laminated diet cards. With those potentially contaminated gloves, he touched the drinking surface of the cups.Review of the provider's 2023 Hand Washing policy revealed that staff should wash their hands when switching between working with raw food and working with ready to eat food.Review of the provider's 2023 Bare Hand Contact with Food and Use of Plastic Gloves policy revealed that staff will use clean barriers such as single use gloves, tongs, deli paper and spatulas when handling food. Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only one task such as working with ready-to-eat (RTE) food or with raw animal food, used for no other purpose and discarded when damaged or soiled, or when interruptions occur in the operation. Additionally, hands are to be washed when entering the kitchen and before putting on the single use gloves (before (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	beginning to work with food) and after removing single use gloves.2. Observation on 2/10/26 at 8:58 a.m. in the kitchen revealed that two thermometer probes were kept in a cup with an unidentified clear liquid. The container had food debris floating around the liquid.Interview on 2/10/26 at 9:02 a.m. with cook L revealed that the above unidentified clear liquid was a sanitizer solution. She said it was changed daily, but she had not changed it yet from the previous day. Testing of the sanitizer solution concentration revealed that it was within acceptable range for proper sanitation. There were food particles floating within the sanitation solution. The sanitization solution was then changed.Observation on 2/10/26 at 11:30 a.m. in the kitchen revealed cook L was preparing to measure the temperature of the chicken that was to be served for lunch that day. She used one of the above-mentioned thermometer probes. She wiped the probe on a cloth that had been sitting on top of a container of papers near the microwave. She did not use an alcohol wipe to sanitize the probe before inserting it into the chicken. There were alcohol wipes available on a neighboring food prep table.Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed that the sanitizer solution used to store the thermometer probes should have been changed every shift. She expected staff to clean the thermometer probes with an alcohol wipe before inserting the probe into the food. She explained it was not acceptable to use a potentially soiled cloth found in the kitchen to wipe the thermometer probe prior to use. She also expected staff to refrain from touching food with potentially contaminated gloves. If each food item had a serving utensil, then the staff would not need to wear gloves.Review of the provider's 2023 Resource: Taking Accurate Temperatures policy revealed to take temperatures, a clean, rinsed, sanitized and air-dried thermometer that is the metal stem type, numerically scaled and accurate to plus or minus 2 degrees Fahrenheit is needed.3. Observation on 2/10/26 at 8:53 a.m. in the kitchen revealed that the two ceiling vents above the walk-in cooler and freezer were caked with a thick layer of dust.Observation and interview on 2/10/26 at 9:21 a.m. in the dish room with dietary aide N revealed that the inside of the dishwasher doors had a thick layer of food scum and limescale buildup. That buildup was also present to the left of the dishwasher, underneath the seam of the dishwasher track where it connected with the dirty dish table. Dietary aide N stated that the dishwasher was delimed once per week, but they did not use any cleaning tools, such as a cloth wipe or dish brush, to scrub areas where the food scum accumulated.Observation on 2/18/26 at 9:41 a.m. in the walk-in cooler revealed there were four fans used to circulate refrigerated air throughout the cooler. All four fans and the grates covering them had a collection of dust. There were streaks of dust buildup on the ceiling. There was more dust buildup on the light fixtures.Continued observation on 2/18/26 at 9:51 a.m. in the walk-in cooler revealed several of the storage shelves were rusty and the chrome or paint coating was chipping away. Several RTE food items were below the rusty parts of the shelves, such as fresh vegetables and fruit.Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed there was not a designated person in the facility to clean the ceiling vents or the fans in the walk-in cooler. She also indicated the rusty shelves might have to be replaced due to the potential for physical contamination of rust falling on the RTE vegetables on the shelf below.Review of the provider's dishwasher deliming schedule for 2025 revealed from July to December 2025, 26 of 31 scheduled cleanings were completed. In December 2025, deliming was completed only once.Review of provider's 2023 Food Storage policy revealed Racks and other storage surfaces should be clean and protected from splashes, overhead pipes, or other contamination (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.)4. Review of provider's dishwashing temperature logs (August 2025 to February 18, 2026) revealed several missed opportunities for temperature documentation. Each monthly log had spaces to record the dishwasher temperature after each meal. There was a total of three temperatures (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	required per day according to the log. In August 2025, there were 10 missing temperature documentations out of 93 opportunities. In September 2025, there were 36 missing out of 90 opportunities. In October 2025, there were 38 missing out of 93 opportunities. In November 2025, there were 32 missing out of 90 opportunities. In December 2025, there were 52 missing out of 93 opportunities. In January 2026, there were 61 missing out of 93 opportunities. From 2/1/26 to 2/18/26, there were 32 missing temperature documentations out of 54 opportunities.Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed that she expected staff to complete the temperature logs for the commercial dishwashing machine after each meal service when the dishes were cleaned.Interview on 2/18/26 at 11:50 a.m. with dietary aide O revealed that he was assigned to the dishwashing duties that shift. He stated that he did not check the temperature of the dishwashing machine and added, but I probably should. He further stated that he did not remember the last time he checked the dishwashing temperatures.Review of provider's 2023 Cleaning Dishes/Dish Machine policy revealed that staff will monitor dish machine temperatures through the dishwashing process. Staff will record dish machine temperatures for the wash and rinse cycles at each meal. The director of food and nutrition services will spot check this log to assure temperatures are appropriate and staff is correctly monitoring dish machine temperatures. Staff will be trained to report any problems with the dish machine to the director of food and nutrition services as soon as they occur. The director of food and nutrition services will promptly assess any dish machine problems and take action immediately to ensure proper sanitization of dishes.5. Observation on 2/10/26 at 8:55 a.m. in the kitchen revealed there were several different covered containers of food, and an uncovered sheet pan of cooked beef patties sitting on the counter. Testing of the food temperatures revealed that the covered container of beef tips in gravy was at 56.1 degrees Fahrenheit, and the beef patties were at 68.9 degrees Fahrenheit.Interview on 2/10/26 at 9:28 a.m. with cook L revealed that the containers of food were designated for lunch that day. They usually prepare the lunch food before breakfast was served, panned it into containers, and placed the containers back in the cooler before they went to serve breakfast. She confirmed the food had been sitting out at room temperature since before she went out to serve breakfast, which she started serving at 7:30 a.m. She stated that it was not normal practice for the lunch food to sit on the counters during breakfast service. She usually put the food back into the cooler, but she had not done so that morning. She planned on using that food for lunch, and her goal final cooking temperature was at least 160 degrees [Fahrenheit].Observation on 2/10/26 at 11:22 a.m. revealed that the final cooking temperatures for the above-mentioned lunch foods were all above the minimum 165 degrees Fahrenheit temperature for reheated food.Observation on 2/18/26 at 9:49 a.m. in the walk-in cooler revealed raw bacon was stored in a cardboard box above a box of RTE mashed potatoes. This potentially exposed the mashed potatoes to cross-contamination from raw meat juices.Observation on 2/18/26 at 9:53 a.m. in the walk-in freezer revealed a box of frozen beef patties that was uncovered and left open to air on the bottom shelf of the storage rack. This potentially exposes the beef patties to physical, chemical, or biological contamination in addition to quality concerns with freezer burn.Interview on 2/18/26 at 9:58 a.m. with dietary manager K confirmed that raw foods should not have been stored above RTE foods. She was not aware of the box of frozen beef patties that was left open to air in the freezer. She further explained that if food was left out on the counter and entered the temperature danger zone [41 to 135 degrees Fahrenheit], it should have been discarded because they did not know how long that food had been sitting out. Dietary manager K explained that food that had been sitting out for over an hour could cause residents to become ill with a foodborne illness. She had not heard of any gastrointestinal illnesses amongst the residents lately.Review of the provider's 2023 Use of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Leftovers policy revealed, Leftovers should be covered, labeled, and dated; then stored appropriately (refrigerated or frozen if necessary) immediately after the end of the meal service. Leftovers that have not been properly stored will be discarded. (When in doubt, throw it out.)6. Observation on 2/10/26 at 9:10 a.m. in the kitchen revealed there was a shelving unit with various baking ingredients like food coloring, flavor extracts, and coffee syrups. Several items were past the manufacturer's Best By or expiry dates, including: [NAME] branded butter extract with an expiry date of 3/3/25, [NAME] branded lemon extract with an expiry date of 3/18/25, egg shade yellow food coloring that had a delivery receipt of 1/6/11, Torani branded sugar-free caramel coffee syrup with Best If Used By 11/24/22, Torani branded coconut coffee syrup with Best If Used By 12/28/25, another bottle of egg shade food coloring with a delivery date of 10/22/13, a bottle of dried cilantro with Best By 2/27/2025, and a bottle of Creme de Menthe coffee syrup with an expiry date of 1/17/21.Observation on 2/18/26 at 9:45 a.m. in the walk-in cooler revealed there was a gallon jug of sweet pickle relish and a gallon jug of thousand island dressing. The cover on the pickle relish was not fully secured and had an unidentified white substance on the inside surface of the lid. The jug of thousand island dressing had what appeared to be mold growing on the outside of the container, on the inside of the lid. and on the handle. There was no opened date written on that container.Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed that they did not use the food coloring, flavor extracts, or coffee syrups often in their baked goods. She was not aware that those items were past the best by dates. She was also not aware of the potentially moldy jug of dressing in the cooler. She guessed the white substance on the inside of the pickle lid could have been something like mayonnaise, but she was not sure.Review of the provider's 2023 Food Storage policy revealed that All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. Food should be dated as it is placed on the shelves if required by the state regulation. Date marking should be visible on all high-risk food to indicate the date by which a ready-to-eat TCS [time and temperature control for safety] food should be consumed, sold or discarded.All containers or storage bags must be legible and accurately labeled and dated. All foods should be covered, labeled and dated and routinely monitored to assure the foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded. All foods should be covered, labeled and dated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, record review, and policy review, the provider failed to ensure medical director EE attended and meaningfully participated in the provider's Quality Assurance and Assessment (QAA) meetings at least quarterly. Findings include:1. Interview on 2/19/26 at 11:25 a.m. with administrator A revealed that the QAA committee meets monthly. She texted medical director EE monthly to remind him of when the meetings were, and he usually texted topics he wished the committee to discuss. He sometimes would attend via telephone. He did not have a nurse practitioner or physician's assistant to attend in his absence. She confirmed she was aware that the medical director was required to attend at least quarterly. 2. Review of the provider's QAA committee binder at that time with administrator A revealed that medical director EE attended the QAA committee meeting via telephone on 1/29/26 (their most recent QAA committee meeting), and he attended in person on 8/13/25. All other months throughout 2025 he either did not attend or only sent a text to administrator A with topics he wanted them to discuss. 3. Review of the provider's July 2025 QAPI (Quality Assurance and Performance Improvement) policy revealed that the medical director was on the QAA committee, and the committee would meet at least quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	103 N Viola St 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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, document review, and policy review, the provider failed to ensure a water management program was in place to mitigate the growth and spread of Legionella (a type of bacterium commonly found in natural water sources). This had the potential to affect all residents, staff, and visitors within the facility. Findings include:1. Interview on 2/18/26 at 12:45 p.m. with maintenance director U revealed:*He checked the in-line water heater temperature every morning, and the temperature range was to be no more than 125 Fahrenheit (F), so he kept it at 117-118 degrees F.*They did not add any chemicals to their water for the prevention of Legionella.*The building's water was not tested for chlorine levels.*He or housekeeping sometimes ran the water and flushed the toilets in the empty rooms, but he did not have a formal plan or documentation for running stagnant water. 2. Review of the November 2025 through February 2026 water heater temperatures revealed that the water heater temperatures were always at 117 degrees F. The water temperature was required to be 122 degrees F to 125 degrees F for control of Legionella. 3. Interview on 2/19/26 at 9:00 a.m. with city water employee HH revealed he did chlorine testing at the nearby upstream facility daily, but not at this nursing home. 4. Interview on 2/19/26 at 12:55 p.m. with director of nursing/infection preventionist B revealed she expected maintenance to follow the federal guidelines for the prevention of Legionella. 5. Interview with administrator A on 2/19/26 at 1:30 p.m. revealed:*She expected maintenance to follow the guidelines to prevent Legionella.*There was a changeover in staff, and no one was monitoring that it was being done.*They did not have a formal process for running stagnant water or making sure the water was the correct temperature to kill Legionella.*She was responsible for ensuring the water management process was followed. 6. The 10/2025 Infection Prevention and Control Policy did not contain information regarding Legionella management and prevention.