STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING B. WING	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4TH ST , WILMOT, South Dakota, 57279

(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/21/26 through 7/23/26. Wilmot Care Center Inc. was found not in compliance with the following requirement: F727. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/21/26 through 7/23/26. Areas surveyed included infection control, misappropriation of property, nursing services, and quality of care/treatment of the residents. Wilmot Care Center Inc. was found in compliance.	F0000		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on Payroll-Based Journal (PBJ) reports, interview, staff schedule review, and facility assessment review, the provider failed to ensure a registered nurse (RN) was scheduled to work for	F0727	F0727 Director of Nursing/scheduler was educated on the need for the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week. Administrator will apply for an RN waiver to cover the days an RN is not available in-house. PRN and Agency RNs will be utilitized to achieve at least 8 consecutive hours a day, 7 days a week RN coverage and a RN waiver will be obtained until RN coverage is achieved 8 consecutive hours a day, 7 days a week. Assistant Director of Nursing/Administrator will track RN daily consecutive hours on a weekly basis and report to the next QAPI meeting and then quarterly thereafter until committee recommends completion.	9-4-2026

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 reverse for further 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
Jan Van Beek	Administrator	8-14-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4TH ST , WILMOT, South Dakota, 57279

(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
F0727 SS = F	Continued from page 1 eight consecutive hours a day, seven days a week for one of four federal fiscal quarters (Quarter 3, 2025). The facility's resident census was 21. Findings include: 1. Review of the Payroll Based Journal (PBJ) report (information of the provider's daily staffing hours for the care of the residents) data for Quarter 3 (April 1 - June 30 2025) revealed the provider did not have RN coverage for eight consecutive hours on 4/18/25, 4/20/25, 5/3/25, 6/2/25, and 6/3/25. 2. Interview on 7/21/26 at 9:06 a.m. with administrator A during the entrance conference revealed the provider did not have any nurse staffing waivers. 3. Review of the provider's nursing staff schedule from 4/2025 through 3/2026 revealed an RN was not scheduled to work on 5/3/25, 5/4/25, 5/31/25, 6/14/25, 6/15/25, 9/6/25, 9/7/25,11/16/25, 11/22/25,11/23/25, 1/1/26, 1/31/26, 2/7/26, 2/8/26, 2/21/26, 2/22/26, 3/21/26, and 3/22/26. 4. Interview on 7/23/26 at 10:15 a.m. with director of nursing (DON) H regarding the provider's nursing staff schedule from 4/2025 through 3/2026 revealed she acknowledged there were several days that an RN was not scheduled to work or was not in the facility, but she was always available by phone, and she had worked some open shifts when she could. She acknowledged they did not have an RN available to work those open RN shifts. 5. Interview on 7/23/26 at 11:55 a.m. with administrator A revealed there was no RN coverage for eight consecutive hours coverage on the schedule from 4/2025 through 3/2026 for multiple days and months. The facility hired contracted travel staff when one of their own staff could not cover an open RN shift, and the DON had covered some open RN shifts. She stated an RN was available by phone when an RN was not in the building. She stated they had advertised, used word of mouth, but had not been able to hire an RN. She stated she had a licensed practical nurse (LPN) who had finished school, and she would cover some of their open RN shifts. The facility had a new timekeeping system that was installed in September 2025. The new system tracked the licensed nurse staff coverage	F0727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	**501 4TH ST , WILMOT, South Dakota, 57279**

(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
F0727 SS = F	Continued from page 2 which included the contracted travel staff's hours. 6. Review of the Provider's 2026 Facility Assessment regarding their staffing plan for licensed nurses revealed, "Director of Nursing: 1 RN full-time (day) –may serve as Charge Nurse RN or LPN – Charge Nurse: 1 for each shift, 24 hours daily 1 Part-time RN to serve as MDS [Minimum Data Set]/Patient Care Coordinator (day/eve [evening]) 1 Part-time RN/LPN to serve as Restorative Nurse (day/eve)1 Part-time RN/LPN as infection Preventionist."	F0727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	**501 4TH ST , WILMOT, South Dakota, 57279**

(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
E0000	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 on 7/21/26. Wilmot Care Center Inc was found not in compliance with the following requirements: E013 and E030.	E0000		
E0013 SS = D	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures,	E0013	E0013 Emergency Preparedness plan agreements were reviewed and Memorandums of Understanding (MOU) for emergency water supply, evacuation and emergency shelter were updated and sent to partners for signatures. Administrator will track the returns of the MOUs and follow-up on any not received timely. Administrator will review and send out annual MOUs at such a time to allow their signing and return within the year timeline. Administrator will track annual MOUs and report at the next QAPI meeting and quarterly thereafter until committee recommends completion.	9-3-26

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 reverse for further 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
Jan Van Beek	Administrator	8/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4TH ST , WILMOT, South Dakota, 57279

(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
E0013 SS = D	Continued from page 1 based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the provider failed to update Memorandums of Understanding (MOU) in the Emergency Preparedness binder for three MOU's (emergency water supply, evacuation, and emergency shelter). Findings include: 1. Record review on 7/21/26 at 9:15 a.m. revealed that the facility's Emergency Preparedness binder located in the administrator's office did not contain updated Memorandums of Understanding (MOU) for an emergency water supply, evacuation, and emergency shelter. The last updated MOU for water supply was dated 7/7/25, for evacuation 6/30/25, and for emergency shelter 6/30/25. Interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0013		
E0030 SS = D	Names and Contact Information CFR(s): 483.73(c)(1)	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	**501 4TH ST , WILMOT, South Dakota, 57279**

(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
E0030 SS = D	Continued from page 2 §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian.	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4TH ST , WILMOT, South Dakota, 57279

(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
E0030 SS = D	Continued from page 3 (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING B. WING	07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4TH ST , WILMOT, South Dakota, 57279

(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
E0030 SS = D	Continued from page 4 (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the provider failed to include a listing of employee contact information in the Emergency Preparedness binder. Findings include: 1. Observation and record review on 7/21/26 at 9:15 a.m. revealed that the facility's Emergency Preparedness binder located in the administrator's office did not contain a list of the employees' contact information. A list was found to be located with other documentation at the nurses' station. An interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0030	E0030 Emergency preparedness binder in the administrator's office, as well as in all the departments, were updated with employee contact information. Administrator will ensure the employee contact information is kept up to date and a correct copy is in the Emergency Preparedness binder in the office, as well as all department binders. Administrator will track that updated employee contact information is located in the Emergency Preparedness binder in the administrator's office and report at the next QAPI meeting and quarterly thereafter until committee recommends completion.	9-1-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4TH ST , WILMOT, South Dakota, 57279

(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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 7/21/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Wilmot Care Center Inc was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K324 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0324 SS = D Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider	K0324		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jan Van Beek	Administrator	8-12-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING 01 - MAIN BUILD... B. WING	07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4TH ST , WILMOT, South Dakota, 57279

(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
K0324 SS = D Bldg. 01	Continued from page 1 failed to perform twice-annual kitchen stove exhaust duct inspections for grease build-up since June 2025. Findings include: 1. Record review on 7/21/26 at 8:50 a.m. revealed documentation that the kitchen hood exhaust duct was cleaned by an outside contractor in June 2025 and on 5/28/26. There was no documentation indicating the ductwork was inspected or cleaned at a six-month interval between those two dates. Interview with the maintenance director at the time of the record review confirmed that finding. He was unaware the ductwork needed to be inspected for cleanliness twice a year.	K0324	K0324 Maintenance supervisor inspected the kitchen hood exhaust duct on June 29, 2026. Maintenance supervisor will add kitchen hood exhaust duct inspections to the semi-annual maintenance checklist to ensure it is checked at least two times a year and cleaned commercially one time per year and as needed. Maintenance supervisor will track kitchen hood exhaust duct inspections and cleaning and report at the next QAPI meeting and quarterly thereafter until committee recommends completion.	9-1-2026

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
	10712	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH STREET WILMOT, SD 57279

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 7/21/26 through 7/23/26. Wilmot Care Center Inc. was found not in compliance with the following requirements: S157 and S206.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation for the soiled linen holding room in the laundry area. Findings include: 1. Observation and testing on 7/21/26 at 8:15 a.m. of the exhaust ventilation grille in the soiled holding room in the laundry area revealed the exhaust was not functioning. 2. Interview with the maintenance director at the time of the above observation confirmed that finding.	S 157	S157 Maintenance supervisor found switch for exhaust fan in the soiled laundry holding room to be turned off at the motor and it has sinced worked properly. Maintenance supervisor/designee will check daily for 2 weeks that the exhaust fan in the soiled laundry room is functioning properly, then weekly for 1 month and then will add it to the monthly maintenance checklist along with all other exhaust fans. Maintenance supervisor will report on the exhaust fan functionality at the next QAPI meeting and then quarterly thereafter until committee recommends completion.	9-1-26
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for	S 206		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jan Van Beek	Administrator	8-12-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10712	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH STREET WILMOT, SD 57279

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 206	Continued From page 1 all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure three of three newly hired employees reviewed (C, E, and F) completed the required orientation training within 30 days of their hire date, and three of three employees reviewed (B, D, and G) completed the required annual training. Findings include:	S 206		

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
	10712	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH STREET WILMOT, SD 57279

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 206	Continued From page 2 1. Review of certified nursing assistant (CNA) C's employee record revealed she was hired on 11/5/25. She did not complete the required orientation training within 30 days of her hire date regarding the topic of advance directives. 2. Review of licensed practical nurse (LPN) E's employee record revealed she was hired on 11/5/25. She did not complete the required orientation training within 30 days of her hire date regarding the topic of advance directives. 3. Review of CNA F's employee record revealed she was hired on 2/4/26. She did not complete the required orientation training within 30 days of her hire date regarding the topic of advance directives. 4. Review of LPN B's employee record revealed she was hired on 12/12/19. She did not complete the required annual training regarding the topics of fire prevention/response, emergency preparedness/procedures, and advance directives. 5. Review of registered nurse (RN) D's employee record revealed she was hired on 3/14/25. She did not complete the required annual training regarding the topics of fire prevention/response, emergency preparedness/procedures, and advance directives. 6. Review of CNA/certified medication aide (CMA) G's employee record revealed she was hired on 10/1/18. She did not complete the required annual training regarding the topics of fire prevention/response, emergency preparedness/procedures, and advance directives.	S 206	S206 Advance directive education was added to new employee orientation packets on July 28, 2026. All staff received fire prevention/response, emergency preparedness/procedures and advance directive education with their July 28 paychecks. Any staff member not getting a paycheck was handed or emailed a copy of the education and quiz. All quizzes were due in by August 10, 2026. Staff were not allowed to work after August 10 until their education was completed and their quiz turned in. An Education policy was created to cover all new hire orientation to be covered within the first 30 days of working and all annual required education . Administrator will track that all new hires receive advance directive education during orientation and within 30 days of hire and all required education is completed annually and within one year of the last education. Administrator/designee will report at the next QAPI meeting on completed new hire and annual completed education and quarterly thereafter until committee recommends completion.	9-1-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 206	Continued From page 3 7. Interview on 7/22/26 at 2:07 p.m. with administrator A revealed she oversaw the employees' orientation and annual training and expected the training to be completed by the due date. The former business manager used to complete the employees' initial 30-day hire orientation education. The facility did not have a policy for the orientation education required within 30 days of an employee's hire date. No advance directive training was completed for any employees. Advance directives was not on the employee training schedule. She was aware the 30-day hire orientation education needed to be completed within 30 days of their hire date. 8. Review of the provider's updated 1/1/26 Mandatory Education policy revealed "In order to ensure resident and employee safety and keep compliant with all state and federal regulations considering mandatory all staff education. In addition to in-person education meetings Wilmot Care Center also provided monthly education that covers "mandatory" educational information, as well as education that is deemed necessary at the time. Quizzes will be included in each employees paycheck/paystub and educational materials will be available in the education binder in the breakroom. Quizzes and educational materials can also be gotten from department managers. All quizzes will be due within 2 [two] weeks of them being in paycheck/paystubs (the Monday before the next payroll). If they are not turned in within 2 weeks, you will receive disciplinary action of a verbal warning which is placed into your employee file."	S 206		