STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/4/25 through 3/6/25. Wilmot Care Center Inc was found not in compliance with the following requirements: F686, F689, F803, F812, F880.

A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/4/25 through 3/6/25. Areas surveyed included medication error, excessive sedation, fall with major injury, unexpected death.. Wilmot Care Center Inc was found in compliance.

IMMEDIATE JEOPARDY NOTICE
Notice of immediate jeopardy was given verbally and in writing on 3/6/25 at 11:52 a.m. to administrator A, and DON B.
*This was related to an observation of their leaking whirlpool tub with water dripping water near a 120-volt electrical box and standing water in that area and tub room after 1 resident had received a bath and another resident had been in the whirlpool ready to get a bath.
*The provider failed to have an immediate plan of action in place and implemented after it had been reported the whirlpool jets had shut off on their own during the cleaning cycle.
*This could potentially create an environment where someone could have been harmed by electrical shock.
*Through interviews and document review, it was identified that there was no plan or education presented to the staff regarding the malfunction of the whirlpool tub to ensure the safety of the residents and staff.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek
TITLE: Administrator
(X6) DATE: 3/27/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 000	Continued From page 1 The immediate jeopardy was removed on 3/6/25 at 1:36 p.m. after the survey team verified the provider had unplugged the Pennar Whirlpool and signage that it was not in use. The current resident census was 23.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview and policy review the provider failed to implement prescribed and care-planned preventative pressure injury interventions for one of one (2) sampled resident who developed pressure ulcers to both of her heels. Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed: *Her admit date was 6/19/23. *Her 12/21/24 Brief Interview for Mental Status (BIMS) assessment score was 11 which indicated	F 686	F686 Resident 2's Prevalon boots were put on immediately and staff was reminded of the importance of using them and where the care plans are kept. Resident 2 has since passed away and currently no resident needs/is using Prevalon boots. Any resident that needs Prevalon boots will have their care plan updated and it will be noted and passed on during shift change report and will be listed on the weekly resident information sheet. A sign will also be posted in the resident room.	3-27-2025 JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 686	Continued From page 2 she had moderate cognitive impairment. *She was legally blind. *Her Braden assessment score was 19 on 12/21/24 which indicated she was as risk for developing pressure ulcers. *A left heel pressure ulcer was first documented in care plan on 2/2/23. *A 11/27/24 doctor's order to paint left heel pressure ulcer with betadine, leave open to air, every day until healed. *On 12/12/24 a new area to her right heel was observed measuring 1 cm by 1 cm black in color and unopened. *A 12/4/24 doctor's order for Prevalon (boots for pressure relief) boots, at all times, and to monitor heels. *A 12/20/24 doctor's order to paint right heel SDTI (suspected deep tissue injury) with betadine daily, leave OTA (open to air), until healed. *A 2/10/25 order for house supplement with meals for wound healing. *Weekly documentation of wound on day shift every Thursday was initiated on 7/17/24. *A care plan focus area indicated she had a pressure ulcer to her left heel and right heel due to immobility. -An intervention for that focus area indicated she required pillow boots on both feet at all times. That was dated 2/2/23 and was revised on 12/4/24. *She needed the assistance of one staff person with all transfers, toileting, bathing, and dressing tasks. *The 3/4/25 nurse documentation on her treatment administration record (TAR) indicated she had her Prevalon boots on. *The kardex (a report of resident care needs) for resident 2 indicated she required pillow boots on both feet at all times.	F 686		JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 686	Continued From page 3	F 686		

2. Observation on 3/04/25 at 10:10 a.m. revealed:
*Resident 2 was sleeping in her recliner in her room.
*She did not have Prevalon boots on.

3. Observation on 3/04/25 at 11:09 a.m. revealed:
*Resident 2 had her slippers and did not have Prevalon boots on.

4. Observation on 3/04/25 at 1:39 p.m. revealed:
*Resident 2 was sitting in a wheelchair with slipper booties on.
*Her Prevalan boots were on the end of her bed.

5. Observation on 3/05/25 at 2:53 p.m. revealed:
*Resident 2 was lying in her bed, on her back, with no Prevalon boots on her heels.
*One boot was in her recliner.
*One boot was on her walker.

6. Interview and observation on 3/5/25 at 2:57 p.m. with certified nursing assistant (CNA) G in resident 2 room revealed:
*She had gotten resident 2 up from bed on the morning of 3/4/25.
*Resident 2 had the Prevalon boots on when she got her up.
*Resident 2 had a bath on 3/4/25.
*She transferred resident 2 from her recliner to her wheelchair for lunch on 3/4/25.
*She forgot to put her Prevalon boots on.
*She was aware resident 2 had wounds on her heels.
*She then placed the Prevalon boots on resident 2 as they were not on her.

7. Interview on 3/5/25 at 3:02 p.m. with CNA H regarding resident 2 revealed:

JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 686	Continued From page 4	F 686		

She knew resident 2 was to wear Prevalon boots but she forgot to put them on her when she put her in bed.
*She was aware she had pressure sores on her heels.

8. Interview on 3/5/25 at 3:42 p.m. with registered nurse (RN) I regarding resident 2 revealed:
*The nurses were to document that Prevalon boots were on in the resident's TAR.
*She checked to see if they were on when she saw resident 2 outside of her room.
*She did not check on resident 2 after they laid her down for her nap today (3/5/25).
*She would complete her TAR documentation at the end of her shift.

9. Interview on 3/6/25 at 10:40 a.m. with director of nursing (DON) B revealed:
*Her expectation for heel lift boots, Prevalon boots or other preventative measures for residents was for staff to:
-Follow doctor's orders.
-Follow the care plan for the resident.

10. Review of the provider's revised 6/21/24 Pressure injury prevention policy revealed:
*"The CNA will follow through with skin care interventions implemented for prevention and treatment of skin concerns per resident's care plan."
*"Routine care should include: redistribute pressure (repositioning, protecting and or offloading, minimize exposure to moisture and keep skin clean, provide appropriate pressure redistributing support surfaces, provide non irritating surfaces, maintain or improve nutrition and hydration status where feasible)."

JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 689	Continued From page 5	F 689		
F 689 SS=L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that one of one whirlpool tub was free of environmental hazards due to an active water leak next to an electrical box in the control panel of the tub. Failure to do so increased the potential risk for immediate serious injury, serious harm, serious impairment, or death as a result of potential electric shock to a resident and staff. Findings include: 1. IMMEDIATE JEOPARDY Observation on 3/6/25 at 7:57 a.m. in the tub room revealed an active water leak that was dripping behind a 120-volt electrical box within the whirlpool's control panel. Standing water covered the floor under the electrical wires and piping of that control panel. An electrical cord extended from above that control panel to the floor and was lying in the standing water. That whirlpool was being used to provide resident bathing. Interviews with administrator A, director of nursing (DON) B, and facility manager/laundry/housekeeping (FM) P indicated that none of them were aware of the leaking	F 689	F689 Immediate Jeopardy was removed on 3/4/2025. The tub was disabled by cutting the power cord on 3/4/2025. It was removed from the facility on 3/26/2025. A new tub was ordered on 3/25/2025 and will be delivered in 4 weeks. The Maintenance Supervisor has included the tub and other resident care equipment on the Preventative Maintenance monthly check sheet in ensure safe operating/use. All nursing, maintenance and housekeeping staff will be trained on their roles and responsibilities for safe usage of all resident care equipment and the new tub. Training will also include procedures for reporting and the follow up of maintenance concerns. Training will occur by 4/1/2025. Copies of the training will be kept at the nurses station for those staff that do not work before 4/1/2025 to review and sign off on. Director of Nursing will monitor all training for nursing staff and Maintenance Supervisor will monitor all training for maintenance and housekeeping staff. A company representative will provide training on usage, cleaning and maintenance of the new tub when it is installed. Director of Nursing will report to QAPI committee at the next meeting on the training of nursing staff on safe usage of resident care equipment and then quarterly for any new staff until committee recommends completed. JMB 3/27/2025	4-2-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 689	Continued From page 6 water from the whirlpool tub near the electrical box in the control panel. CNA F was told to refrain from using the whirlpool tub until further notice. At the time of the survey, staff could not accurately verify that the whirlpool tub was safe to use. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy was given verbally and in writing via email on 3/6/25 at 11:52 a.m. to administrator A, and DON B related to the leaking whirlpool tub with water dripping near a 120-volt electrical box, potentially creating an environment where someone could be shocked. They were asked for an immediate jeopardy removal plan. IMMEDIATE JEOPARDY REMOVAL PLAN On 3/6/25 at 1:29 p.m. DON B provided the survey team a written immediate jeopardy removal plan via email. The removal plan, after agreed-upon revisions, with guidance from the long-term care advisor for the South Dakota Department of Health (SD DOH), was approved on 3/6/25 at 1:36 p.m. "F689: Response Plan for Removal of Immediate Jeopardy 3/06/25 3/6/25 at [8:28 a.m.]: Whirlpool tub was inspected by maintenance found to be leaking around the voltage box. Two surveyors, DON, and Administrator were present during the inspection. Surveyors left the tub room at approximately 8:45 a.m. 3/6/25 at [8:45 a.m.] Pennar Whirlpool was unplugged after maintenance took note of area that was leaking. The Whirlpool Tub will remain unplugged and not in use. Bath aide was informed that the Whirlpool tub will not be used and at this time it is unplugged. The shower area	F 689	F689 continued: Maintenance Supervisor will report on Preventative Maintenance checks and maintenance and housekeeping training at the next QAPI meeting and then quarterly until committee recommends completed.	JWB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 689	Continued From page 7 can be safely used. 3/06/25 at [8:55 a.m.] Potential for injury has been removed. The shower room is operable and safe. As of 3/6/25 at [9:00 a.m.]: Calls were made to the Board of Directors informing them that quotes will be coming in for a new whirlpool tub and it will need to be replaced as soon as the new one arrives. A quote was received, and the Board of Directors are reviewing. Extended security measures to ensure that the whirlpool tub cannot be used: An Out of Order Sign has been placed on the door of the tub door and the face of the tub. The cord has been secured so that it is not usable, and no power will be in that area. The tub reservoir has been emptied, and the water has been shut off going to the tub so there will not be standing water around the tub. When the new tub is installed weekly inspections of the Whirlpool/tub room will be completed to ensure it remains safe and functioning properly. Staff will be educated to complete work orders to ensure the maintenance has a record of any and all issues in the facility. Education will be given by the Director of Nursing to all certified nursing assistants/mediation [medication] aides/bath aide and nurses by 3/14/25 regarding how to complete a work order, what needs to be put on a work order, and where the work order goes. They will also be educated that maintenance has been instructed to inform those employees giving him verbal issues will be told to complete a work order. If the work order is not completed there is a concern that the issue will not be resolved."	F 689		JVB 3/27/2025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 On 3/6/25 at 1:28 p.m. administrator A verified that the whirlpool yellow electrical cord had been cut in half, therefore no longer could provide power to the whirlpool tub. On 3/6/25 at 1:45 p.m. after on-site verification, the survey team determined the immediacy was removed. After removal of the immediacy, the severity and scope of the citation level was "F" with guidance from the long-term care advisor for the South Dakota Department of Health. The resident census was 23. 2. Observation and interview on 3/6/25 at 7:57 a.m. of the whirlpool tub in the tub room that was located on the West hallway of the facility with certified nursing assistant (CNA) F revealed: *The whirlpool tub had an active leak that was dripping just behind a 120-volt electrical box within the control panel. -There was an unidentified green sludge noted to the polyvinyl chloride (PVC) piping where the water had been dripping down. -There was standing water that had covered the floor under the electrical wires and piping of the control panel of the whirlpool tub. -There was a dirt substance that was on the floor within the standing water. -There was a yellow electrical cord that was found to be above the electrical wiring of the control panel area that extended downward towards the floor and had been lying in the standing water. -There was a dried dirt substance on top of all the piping and electrical wiring within the control panel. -There was a nine-inch by thirteen-inch cake pan that was sitting directly under one of the PVC	F 689		JMB 3/27/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 689	Continued From page 9 pipes. -The inside of the cake pan was dry and did not have any water in it. -The pan was corroded and looked as if it had been there for quite some time. -The whirlpool tub metal frame had rust noted to it and the paint was chipping. *CNA F had indicated that the doors for the control panels had been removed, due to the doors continuously falling off. -The control panel doors were found resting next to the whirlpool tub with a blue piece of tape on them. *CNA F stated, "I typically have a mop in here to mop up all the water in between giving baths to residents." *CNA F had just given a resident a bath, prior to the observation of the active leaking water. *She indicated she first started as a bath aide in November of 2024 and the whirlpool tub was broken then and was not able to be used. *There was a standing shower and shower chair available in the bathing room that was operable if needed. -She stated, "I used the shower and shower chair to give baths when I first started as a bath aide." -She stated, "The tub was fixed in December of 2024 and then I was able to start using it." *CNA F indicated that she had told FM P on several different occasions about the whirlpool tub leaking but did not know the specific dates that she had told him. -She indicated that she did not fill out a "work order" to give to the maintenance department to notify them of the tub leaking. 3. Observation and interview on 3/6/25 at 8:28 a.m. of the whirlpool tub in the bathing room with Administrator A, DON B, and FM P revealed:	F 689		JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 689	Continued From page 10	F 689		

*Administrator A and DON B were not aware of the whirlpool tub actively leaking directly behind the 120-voltage electrical box.
-DON B had stated, "Sometimes the whirlpool tub shuts down on its own."
*FM P stated, "That's not from me," when asked if he knew why the nine-inch by thirteen-inch cake pan had been placed on the floor under the whirlpool PVC piping.
*At 8:45 a.m., administrator A had directed FM P to unplug the yellow cord that supplied the electrical power to the whirlpool tub.
-The yellow electrical cord was unplugged at that time.

4. Interview on 3/6/25 at 9:32 a.m. with DON B revealed:
*DON B provided the maintenance log sheets for the last 6 months.
-She stated, "Everything may not be on the maintenance log, as some staff confront him in the hallway and don't fill out the little slip."
*Review of the log sheets at that time revealed there had been one log entry indicating that the whirlpool tub needed maintenance. "Work order repairs: Tub pump short circuit, Area- Tub Room, Origination date: 11/14/24, Completed date: 11/20/24- Parts ordered: Part ordered."

5. Interview on 3/6/25 at 10:52 a.m. with FM P revealed:
*He confirmed that CNA F informed him of the leaking whirlpool tub on several occasions.
*He had indicated he may have forgotten about that because it had not been written down on the maintenance log sheets.
*He stated, "Sometimes I just fix it right away," indicating that he tended to the maintenance request immediately if something was not working

JMB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 689	Continued From page 11 correctly.	F 689		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure they provided residents' adequate nutrition needs and followed the dietician-approved menu. Findings include: 1. Observation of the kitchen on 3/4/25 from	F 803	F803 Cook L was verbally educated on 3-10-2025 regarding the importance of serving exactly what was on the Dietitian approved menus and the procedure to follow if menu items can not be found. Dietary Manager (DM) reviewed the policy and procedure for substituting menu items. All dietary staff will be in-serviced on 3-28-2025 on the importance of serving exactly what is on the menu and the nutritional requirements of menus. Policy for substituting menus items will also be discussed. Any staff member that is not present will be in-serviced before their next shift. Dietary Manager (DM) will monitor menus and items served daily for 2 weeks, then 2x a week for 2 weeks, then weekly for 2 weeks, then 2 times a month for 2 months and then monthly. DM will report serving of menu items at the next QAPI meeting and then quarterly until committee recommends completed.	4-1-2025 JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ____ B. WING ____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 803	Continued From page 12 11:00 a.m. to 12:30 p.m. revealed: *Cook L plated one cup (c) of chicken and rice casserole, a half c of peas and carrots, and a piece of cake. *The menu called for one c chicken and rice casserole, one half c of peas and carrots, one half c of coleslaw and piece of cake. 2. Interview with dietary manager (DM) K on 3/4/25 at 12:30 p.m. about the lunch meal service revealed: *She did not know the coleslaw had not been delivered. *She had not checked if staff had served the residents' meals as identified on the approved menu. *She expected the cook to come to her if a menu item was unavailable and she would make the food substitution. *They did not have a policy about menu changes. 3. Interview with cook L on 3/5/25 at 9:34 a.m. regarding the 3/4/25 lunch menu revealed: *The coleslaw had not arrived from the supplier. *When a food item was not available, he had not replaced it with a substituted item. *He had not brought the missing food item to the attention of the dietary manager. *He was unaware of the nutritional requirements of the menu. 4. Interview on 3/5/25 at 3:18 p.m. with registered dietician (RD) J revealed: *She provided oversight and approval of the menus served by the provider. *She expected all menu food items to be served. *If an item was not available, an appropriate substitution of like nutritional value should have	F 803		JMB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ___ B. WING ___	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 803	Continued From page 13 been made. *She expected the dietary manager to identify the appropriate substitution. *Residents were underserved one serving of vegetables if they did not receive the coleslaw. 5. Interview on 3/6/25 with Administrator A about the menu revealed: *The kitchen staff had all been trained by the previous dietary manager. *She felt there was room for improvement in all areas of the kitchen. *She was unaware the full menu had not been served on 3/4/24. *She expected the dietary manager to be aware if the menu was not followed. *The residents did not receive the full nutritional requirement for the meal served on 3/4/25.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 812	Continued From page 14 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to label and store food products according to policy and acceptable food standards and discard food products on or before the best by date. Findings include: 1. Observation on 3/4/25 from 8:17 a.m. to 8:30 a.m. of the walk-in cooler in the kitchen revealed: *One sandwich in a zipper bag with no label or date. *Three quarts of lemon juice with a best by date of 2/10/25. *One opened gallon of Italian dressing dated 1/23/25 to 2/23/25. *Seven containers of sour cream with a best by date of 2/21/25. *One full flat of tomatoes. Two of those tomatoes had rotted to less than half their size. *One partial flat of tomatoes with 12 of 12 tomatoes with mold in the stem area. *Seven three-pound boxes of cheese with best by dates of 10/14/24. *Three gallons of skim milk with best by dates of 3/2/25. 2. Observation on 3/4/25 from 8:35 a.m. to 8:45 a.m. of the shelf above a food preparation table revealed seven salad dressing containers that contained dry cereal with their contents written on the lids, including: *Crisped rice, with no dating on the container. *Cinnamon toast cereal with a piece of tape on it that was dated 11/19 to 12/19. *Corn flakes with a piece of tape on it that was dated 12/28-1/28.	F 812	F812 Dietary Manager inspected the food in the coolers and dry storage and discarded all outdated and incorrectly labeled food items. All dietary staff will be in-serviced on 3-28-2025 on the importance of dating leftovers correctly, legible and accurate dating and labeling of all containers, and the checking of outdates and not using any food item that is outdated. Any staff member that is not present will be in-serviced before their next shift. Dietary Manager (DM) will monitor the checking of outdates, labeling and dating of leftovers and all containers daily for 2 weeks, then 2x a week for 2 weeks, then weekly for 2 weeks, then 2 times a month for 2 months and then monthly. DM will report on outdates, labeling and dating of leftovers and containers at the next QAPI meeting and then quarterly until committee recommends completed.	4-1-2025 JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 812	Continued From page 15	F 812		

3. Observation on 3/4/25 at 8:43 a.m. of the shelf above a smaller food preparation table revealed:
*One bottle of honey with a best buy date of 11/2022.
*One bottle of apple cider vinegar with a best by date of 3/20/23.

4. Observation on 3/5/25 at 9:30 a.m. of the walk-in cooler revealed that all but one gallon of the expired food products observed on 3/4/25 remained on the cooler shelves.

5. Interview on 3/4/25 at 8:45 a.m. with cook L revealed:
*He stated the cereal had always been kept in those salad dressing containers observed above.
*He refilled them almost every day.
*He did not put the dated tapes on those containers.
*The dates on the tape meant the day it was opened and the day it was to be discarded.
*He did not know why some of the food dates were passed.
*He thought the dietary manager was responsible for checking the dates on the food products.

6. *Interview on 3/4/25 at 12:30 p.m. with dietary aide (DA) M and dietary manger (DM) K regarding the best by date on the skim milk that was served at lunch revealed:
*DA M had not looked at the date.
*DM M had not noticed that the milk was past the best by date.
*DM K then poured the milk down the drain.

7. Interview on 3/6/25 at 10:18 a.m. with dietary manager revealed:
*She expected all staff to check the the best by

JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 812	Continued From page 16 dates on products. *She did not have a regular schedule or a staff member assigned to inspect food products and dates. *She was unaware of the quantity of food items in the walk-in cooler that were in poor condition or outdated. 8. Interview on 3/6/25 at 3:55 p.m. with Administrator A revealed: *She stated she had many ongoing frustrations with the kitchen and food service. *The previous dietary manager left at the end of 2024 would not take direction given to her, and she had trained all of the current staff. *She would have expected expired food items to be discarded and not served. 9. Review of the provider's September 2021 Food Storage policy revealed: *All containers must be legibly and accurately labeled. *Leftover food is clearly labeled and dated before being refrigerated. *Food should be covered, labeled, and dated. *All food should be dated with the date that it was open and expires three days later unless it was frozen packaged meat then it expires in 10 days.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 17 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	F880 Infection Preventionist (IP) put behind the door personal protection equipment (PPE) holders and signage in all rooms falling under the Enhanced Barrier Precaution (EBP) policy. The IP updated the EBP policy to include the PPE holders, signage and language describing exactly when to use and what PPE to use. Care plans were updated for all residents that require EBP. All nursing staff will be in-serviced on the EBP policy and procedures, including when and what to use and the PPE holder placements by April 2, 2025. Any nursing staff member not working by that date will be in-serviced at their next shift. Individual checklists will be made for each resident that requires EBP usage and will be in a binder at the nurses station. IP or designee will monitor EBP usage daily for 2 weeks, 2x a week for 2 weeks and then weekly. IP will report correct EBP usage at the next QAPI meeting and then quarterly until committee recommends completed.	4-2-2025 JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 18 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: A. Based on interview, observation, and record review, the provider failed to ensure appropriate infection control policies were followed for: *Use of enhanced barrier precautions (gloves and gown use when providing contact care) for one of one sampled resident (14) with a diagnosis of methicillin resistant staphylococcus aureus infection (MRSA) infection. *Use of personal protective equipment (PPE) for two of two sampled residents (17 and 6) with indwelling catheters. Findings include: 1. Interview on 3/4/25 at 9:45 a.m. with resident 14 in her room revealed: *She had a left below knee amputation (LBKA) on 4/18/24. *She stated that the incision had not healed properly. *She had tested positive for MRSA in the wound	F 880		JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ___ B. WING ___	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 19 before Thanksgiving. 2. Observation on 3/4/25 at 9:45 a.m. and 10:26 a.m. of resident 14's room, door, and the hallway outside of the room revealed no symbols or signage that indicated enhanced barrier precautions were required when providing care to resident 14. 3. *Interview on 3/5/25 at 11:20 a.m. with resident 14 in her room revealed: *The wound care nurse used a gown, face shield, and gloves when she had MRSA in November but just uses gloves now. * Facility staff used gloves when they provided her wound care. *Caregiver staff had not used gloves or other items of PPE when they assisted her with dressing, transferring, or bathing. 4. Interview on 3/5/25 at 11:25 a.m. with CNA N revealed she was not aware that she should have used any precautions when providing care or having close contact with resident 14. 5. Interview on 3/5/25 at 4:00 p.m. with RN I regarding enhanced barrier precaution (EBP) with resident 14 revealed: *She would have expected staff to use EBP when providing her care that required contact. *She considered resident 14 to be an accurate historian and if she stated that staff only used gloves when dressing her wound, that was likely accurate. *Resident 14 was receiving antibiotics because previous attempts to stop the antibiotic resulted in increased drainage of her wound and decreased wound healing.	F 880		JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 20 6. Interview on 3/5/25 at 4:40 p.m. with Infection Preventionist C revealed: *She had initiated EBP in the facility that week for the four residents who required it. *She expected staff to use EBP when having any close contact with those identified residents, but not for activities such as delivering water to the room. *In response to what she meant by recently, she stated that it had been started this week. *She hung EBP posters in those four residents/ rooms. *She emailed all staff to be use EBP when appropriate. *She had provided a staff in-service on PPE in October, 2024. *She expected all staff to know when and how to properly use EBP. *She was not surprised that staff were not using EBP as they had just initiated it that week. *She considered EBP was required for resident 14's care because she had MRSA. 7. Interview on 3/5/25 at 4:58 p.m. with director of nursing (DON) B revealed: *She would expect staff to have used gown and gloves with resident 14 when working with her wound. *She would not expect staff to use EBP when performing daily tasks that did not expose the wound drainage. *The wound was covered with an occlusive dressing, which she described as creating a seal over the wound. *Resident 14's wound care was provided by contracted company staff who saw her weekly. 8. Review of resident 14's electronic medical record (EMR) on 3/5/25 revealed:	F 880		JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ____ B. WING ____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 21 *On 11/5/24, she was diagnosed with a MRSA infection in the drainage from her LBKA wound. *No further lab results to indicate that presence or absence of MRSA were located. *On 1/29/25, her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated that she was cognitively intact. 9. Review of the Kardex (pocket care plan) dated 2/28/25 for resident 14 revealed no information regarding her wound or the need for staff to use EBP when providing cares. 10. Review of the care plan showed the most recent revision on 12/20/24 contained no information regarding her MRSA diagnosis, wound care, or use of EBP. Review of the facility's enhanced barrier precaution policy and procedure policy dated 10/2/24 revealed that use of EBPs was indicated for residents with: *" Infection or colonization with a CDC targeted MDRO when contact precautions do not otherwise apply." *Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. B. Based on record review, observation, interview, and policy review the provider failed to ensure proper use of personal protective equipment (PPE) for two of two sampled resident (17 and 6) who had indwelling catheters. 1. Review of resident 17's electronic medical record (EMR) on 3/4/25 at 8:00 a.m. revealed: *She had a urinary catheter. *Review of her most recent care plan did not indicate that she was on enhanced barrier	F 880	JVB 3/27/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 22 precautions (EBP). *On 2/1/25, her Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated that she was cognitively intact. 2. Observation of resident 17's room on 3/4/25 at 8:17 a.m. revealed: *There was no sign that indicated she was on EBP. -There was no personal protective equipment (PPE) outside of her room for staff to don. 3. Observation on 3/5/25 at 3:53 p.m. of resident 17 revealed: *CNA F was assisting resident 17 with her cares with glove use only. *She had a urinary catheter. *There was an EBP sign hanging on the wall above the light switch in the resident's room. -There was a box of gloves sitting on a shelf in resident 17's room along with personal items. 4. Interview on 3/5/25 with certified nursing assistant (CNA) G regarding EBP for resident 17 revealed: *She had never been on EBP and stated, "I had always wondered about that." 5. Observation and interview on 3/5/25 at 5:25 p.m. with resident 17 revealed: *She had indicated nursing staff assist her with her catheter. -A urinary catheter bag was hung on the frame of the resident's bed. -She stated, "I have had a catheter the whole time I have been here." -She stated, "They wear gloves but not a gown." 6. Interview on 3/6/25 at 2:10 p.m. with resident	F 880		JVB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 23 17 revealed: *She stated, "There are usually gowns in the bottom drawer" the bottom drawer is within resident 17's personal closet door in her room. -There were no gowns in the drawer at that time for staff to don. *She stated, "Just today they started wearing gowns when doing cares with my catheter." 7. Review of resident 6's EMR on 3/4/25 at 8:00 a.m. revealed: *She had a urinary catheter. *Review of her most recent care plan did not indicate that she was one either EBP or contact isolation (CI) precautions. *On 1/15/25, she was diagnosed with MRSA infection that was identified in her urine. *On 1/21/25, her Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated that she was cognitively intact. *She had colonization of Methicillin-resistant Staphylococcus aureus (MRSA) in urine and on antibiotic therapy. This could cause confusion for staff. 8. Observation of resident 6's room on 3/4/25 at 8:17 a.m. revealed: *There was a sign on the inside of her room that was visual upon entrance to room, indicating she was on CI. -PPE was outside of her room for staff to don. 9. Observation and interview on 3/6/25 at 3:23 p.m. with resident 6 revealed: *Nursing staff assisted her with her catheter. -A urinary catheter leg bag was attached to the resident's lower right leg and ankle. -She stated, "They only wear gloves when working with my catheter, they maybe have worn	F 880	JMB 3/27/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 24 a gown once or twice." 10. Observation on 3/6/25 at 3:27 p.m. with resident 6 revealed: *CNA N had worn a gown, shoe covers, and gloves when caring for the resident's catheter. -She did not wear face protection. -The urine had been disposed of in resident 6's personal toilet in her room. -She used a spray hose attached to the toilet in the resident's bathroom to clean out the container she collected the urine in. -There was notable water that had sprayed back out from the container when she initiated the sprayer to release water to clean it. 11. Observation on 3/5/25 at 3:53 p.m. of resident 6 revealed: *She had a urinary catheter. *She had an EBP and a CI sign hanging in her room. 12. Interview on 3/4/25 at 8:30 a.m. with housekeeper O revealed: *She was not aware of how to clean residents' rooms who were on EBP. -She stated, "I would clean them like I would any other room and wear gloves." -She stated, "When they have the extra stuff outside of their rooms like the gowns, then I know I need to wear that." 13. Interview on 3/5/25 with director of nursing (DON) B revealed: *She would expect staff to follow the EBP policy when caring for a resident with an indwelling catheter. Review of the provider's enhanced barrier	F 880	JVB 3/27/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
F 880	Continued From page 25 precautions policy and procedure dated 10/2/24 revealed that the use of EBPs was indicated for residents with: *" Infection or colonization with a centers for disease control and prevention (CDC) targeted multi-drug-resistant organisms (MDRO) when contact precautions do not otherwise apply." *" Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. EBP does not apply to shorter-lasting wounds such as skin breaks and skin tears covered by a bandage." *"Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies." *"EBP is used when performing the following high-contact resident care activities: *"Dressing." *"Bathing/Showering." *"Transferring." *"Providing Hygiene." *"Changing linens." *"Changing briefs or assisting with toileting." *"Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator." *"Wound care: any skin opening requiring a dressing."	F 880	JYB 3/27/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 3/5/25. 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 E004 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek | TITLE: Administrator | (X6) DATE: 3/27/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ____ B. WING ____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan agreements (emergency water, evacuation transfer) annually. Findings include: Record review on 3/5/25 at 3:38 p.m. revealed no documentation that the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, the emergency water, and transfer agreements had not been updated annually since 2021.	E 004	E004 - Emergency Preparedness plan agreements were reviewed and the memorandums of understanding (MOU)/agreements for emergency water and transfer agreement were updated and sent to partners for signatures. The entire Emergency Preparedness (EP) plan will be reviewed and updated as needed and presented to the QAPI Committee for approval. The Administrator will review the EP and MOUs on an annual basis and update them as needed and present them to the QAPI Committee for review and approval on an annual basis. Administrator will report to QAPI committee on updated MOUs and EP at the next QAPI meeting and then quarterly until committee recommends completeness.	4-1-2025 JMB 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING ______ B. WING ______	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
E 004	Continued From page 2 Interview with the administrator on 3/5/25 at that same time confirmed those findings.	E 004		

JYB 3/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	**501 4TH ST** **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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 3/5/25 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 K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________ b) Who provided system test _____________ c) Water system supply source _____________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, measurement, and	K 353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek
TITLE: Administrator
(X6) DATE: 3/27/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST 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) COMPLETION DATE
K 353	Continued From page 1 interview, the provider failed to maintain at least 18 inches of unobstructed space under one randomly observed sprinkler deflector. The table linen storage closet in the dining room was observed to be obstructed. Findings include: 1. Observation at 11:02 a.m. on 3/5/25 revealed a sprinkler head in the table linen storage closet in the dining room was obstructed by napkins on a storage shelf. Those napkins were approximately only 12 inches below the bottom of the sprinkler head deflector. That shelf and those items would interrupt the proper discharge and operation of the sprinkler head. Interview with the administrator at the time of the observation revealed she was not aware of the obstructed sprinkler head.	K 353	K353 - All tablecloths and napkins in the dining room linen closet were removed from under the sprinkler head. Maintenance staff will mark shelf to ensure nothing is put on the shelf within 18 inches of the sprinkler head. Maintenance staff will add linen and storage closets to weekly Preventative Maintenance schedule to make sure nothing is stored within 18 inches of the sprinkler heads. Maintenance Supervisor will report to QAPI committee at the next meeting about closet storage too close to sprinkler heads and then quarterly until committee recommends completed.	4-1-2025

JMB 3/27/2025

PRINTED: 03/18/2025
FORM APPROVED

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 ______	03/06/2025

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 from 3/4/25 through 3/6/25. Wilmot Care Center Inc was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jan Van Beek, TITLE Administrator (X6) DATE 3/27/2025