STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435123	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walworth County Care Center, Inc	**4861 LINCOLN AVENUE , SELBY, South Dakota, 57472**

(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 4/28/26 through 4/30/26. Walworth County Care Center, Inc was found not in compliance with the following requirements: F604, F658, F686, F689, and F880.	F0000		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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;	F0880	On 05-01-26 DON and ADON reviewed and were educated by the LNHA on the Enhanced Barrier Precautions criteria and policy. This education included the requirement for use with residents that have pressure wounds, and/or indwelling medical devices. All current staff working during the week of survey were educated on 05-01-26, by the ADON/infection control nurse at the all staff center chat that is held daily. This education included EBP policies, and the specific education on the use of PPE to include gown and gloves for resident transfers and cares. Other education that occurred included proper hand hygiene before and after resident contact, to avoid touching resident belongings with unclean hands, and proper cleaning and disinfection of shared resident care equipment including the Easy Stand lift following resident use. All nursing staff were reeducated on the IC policies, by the ADON/IC on 05-13-26 to include EBP, cleaning of shared resident items between use and proper HH. The resident 12 care plan was updated on 05-14-2026 by MDS nurse to reflect the need for EBP related to the pressure ulcers identified. DON will review 24 hour report daily to ensure resident conditions are known and complete one-on-one communication with the charge nurse each day to identify and address nursing concerns to include the need for EBP with change of condition and any other identified infection control needs. This will ensure timely identification and ensure practices are initiated. All environmental services staff were educated on 05-13-26 by the Environmental Services Director and Housekeeping Supervisor on the Infection Control policy and practices, to include proper glove use and changing and handling of resident care items when cleaning resident rooms. On 5-11-2026 the ADON/IC nurse initiated infection Control Audits to include proper PPE for EBP, cleaning of resident equipment after use, proper hand hygiene, and housekeeping room cleaning. 10 random audits will be done weekly for 4 weeks,6 audits weekly for 4 weeks and 2 audits weekly for 4 weeks or until substantial compliance is achieved. All audits/findings will be taken to QAPI team monthly by the ADON/IC or designee for review and discussion.	05-14-2026

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
Trista Bates	LNHA	05-19-2026

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F0880 SS = E	Continued from page 1 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices by: One of one certified nurse aide (CNA)/registered medication aide (RMA) (N) and one of one RMA (O) who did not wear gowns, gloves, or perform hand hygiene (handwashing or sanitizing hands) while providing care for one of one sampled resident (1) on enhanced barrier precautions (EBP) (glove and	F0880		

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F0880 SS = E	Continued from page 2 gown use when providing contact care). One of one observed CNA/RMA (N) who did not clean an EZ stand lift (a mechanical lift used to assist from a seated to a standing position) after it was used to provide care for one of one sampled resident (1) on EBP. One of one observed registered nurse (RN) (K) and one of one observed CNA (L) who did not wear a gown while providing care for one sampled resident (12) with open wounds on her buttocks and was not identified as needing to be on EBP. One of one observed housekeeper (Q) who did not use gloves or perform hand hygiene, and touched surfaces and resident's items with unclean hands while cleaning two of two sampled residents' (9 and 14) rooms. Findings include: 1. Observation on 4/28/26 at 2:20 p.m. in resident 1's room revealed there was a sign on the room door that indicated EBP was required. Without putting on gowns or gloves, CNA/RMA N and CNA/RMA O transferred resident 1 from his wheelchair to his recliner using an EZ stand lift. After ensuring the resident did not need any further assistance, CNA/RMA N and CNA/RMA O exited the room without performing hand hygiene. CNA/RMA N placed the EZ stand lift across the hall outside of the resident's room without cleaning it, then walked toward the nurses' station away from the resident's room. There was a canister of germicidal wipes in a holder near the base of the EZ stand lift. 2. Interview on 4/28/26 at 2:25 p.m. with CNA/RMA O regarding resident 1 revealed she was expected to wear a gown and a pair of gloves when she transferred that resident. After she completed that resident's care, she was to remove the gown and gloves, discard them into a trash can, and then perform hand hygiene. She felt she did not follow those expectations because she "got distracted." 3. Interview on 4/29/26 at 12:30 p.m. with CNA/RMA N revealed she was to wear a gown and a pair of gloves when she assisted CNA/RMA O with transferring resident 1 on 4/28/26, but she did not. She did not clean the EZ stand lift that was used during that transfer after she removed it from the	F0880		

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F0880 SS = E	Continued from page 3 resident's room, but she should have. 4. Interview on 4/30/26 at 11:55 a.m. with assistant director of nursing (ADON)/infection preventionist (IP) C revealed resident 1 was on EBP because he had a Foley catheter (an indwelling tube inserted into the bladder to drain urine). Infection prevention and control practices were not implemented by CNA/RMA N and CNA/RMA O when they did not put on gowns and gloves before they transferred resident 1, did not perform hand hygiene after they transferred resident 1, and did not clean the EZ stand lift after it was used for that transfer. 5. Observation and interview on 4/28/26 at 2:39 p.m. with resident 12 in her room revealed she was sitting on a pressure-relieving cushion, and she stated she had an open sore on her bottom. 6. Interview on 4/29/26 at 1:22 p.m. with licensed practical nurse (LPN) H revealed that resident 12 had a stage II pressure ulcer (2; open wound or blister with partial-thickness skin loss) to her right and left buttock, and a new pressure ulcer was identified on her right heel yesterday (4/28/26). 7. Observation and interview on 4/30/26 at 9:37 a.m. of registered nurse (RN) K and CNA L assisting resident 12 use to the bathroom revealed that RN K and CNA L did not put on gowns, and they put on a pair of gloves. Resident 12 had an open stage II pressure ulcer to her inner right and left buttocks. CNA L applied a silicone barrier cream to her pressure ulcer and the rest of her buttocks. 8. Interview on 4/30/26 at 9:53 a.m. with RN K revealed that resident 12 did not have EBP interventions in place. She explained that resident 12 did not need to be on EBP since her pressure ulcer did not have any drainage. 9. Interview on 4/30/26 at 10:00 a.m. with ADON/IP C revealed a resident needed to be EBP if they had a chronic wound or an indwelling medical device. She felt resident 12 did not need to be on EBP because her pressure ulcer was not chronic. If her pressure ulcer was not healed within thirty days, then ADON/IP C would put resident 12 on EBP.	F0880		

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F0880 SS = E	Continued from page 4 10. Review of resident 12's EMR revealed she was readmitted to the facility on 3/30/26. Her 4/17/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Resident 12's wound assessments indicated her pressure ulcer to her right inner buttocks was identified on 4/6/26, and her left inner buttocks was identified on 4/27/26. Her 4/28/26 care plan indicated she had a pressure ulcer to her left and right inner buttocks. Her care plan did not indicate she was to be on EBP. 11. Interview and electronic medical record (EMR) review on 4/30/26 at 11:39 a.m. with director of nursing (DON)/wound nurse B revealed resident 12 had a pressure ulcer to her right and left inner buttocks, and she was not aware that resident 12 developed a pressure ulcer on her right heel on 4/28/26. She felt resident 12 did not need to be on EBP because she thought their policy indicated EBP was required if a resident had a chronic wound or an indwelling medical device. 12. Observation on 4/29/26 at 8:31 a.m. of housekeeper Q cleaning resident 9's room revealed she was mopping the floor. She finished mopping and removed the mop head with her ungloved hands. She did not wash her hands before she touched the resident's door handle to exit the resident's room and close the door. With unclean hands, she opened resident 14's door, put on a pair of gloves, cleaned the toilet bowl with a toilet brush, and used paper towels to dry the toilet brush container. With those same gloved hands, she moved the resident's water glass, denture cup, and soap bottle from the sink to the top of the toilet. With those same gloved hands, she cleaned the sink, put the denture cup, glass, and soap bottle back on the sink, and then wiped the grab bars attached to the wall by the toilet. She removed those gloves and discarded them in the trash can.	F0880		

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F0880 SS = E	Continued from page 5 Without washing her hands, she swept the floor, grabbed the door handle to move the door, and swept behind the door. She mopped the floor, removed the mop with her bare hands, and touched the door handle to pull the door closed when she exited the room. Housekeeper Q did not wash her hands before she put on a pair of gloves. She stated she was going to clean another room. 13. Interview on 4/30/26 at 11:00 a.m. with housekeeper Q revealed she was supposed to wash her hands after cleaning a bathroom, when she was done mopping, and between cleaning residents' rooms. She stated she was supposed to wash her hands to prevent the spread of germs and verified that she did not wash her hands during the observations on 4/29/26. 14. Interview on 4/30/26 at 3:37 p.m. with director of food and nutrition/housekeeping J and housekeeping/laundry supervisor R revealed that the housekeeping staff were to wash their hands before putting on gloves, after removing their gloves, after cleaning a bathroom, and before and after mopping. When they were done cleaning a resident's room, they were to wash their hands. Director of food and nutrition/housekeeping J indicated that not performing hand hygiene increased the risk for spreading infection and germs within the facility. 15. Review of the provider's revised December 2024 Enhanced Barrier Precautions policy revealed, "EBP are utilized to prevent the spread of multi-drug resistant organisms (MDROs) during high contact resident care activities." EBP were to be used when "A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained..." and "EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply." "Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:... changing [resident's incontinence (involuntary urine or bowel leakage)] briefs or assisting [the residents] with toileting and transferring."	F0880		

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F0880 SS = E	Continued from page 6 16. Review of the provider's revised September 2022 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed "Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment)." 17. Review of the provider's undated Proper Procedure to Clean a Room document revealed that the staff were to wash their hands after cleaning a bathroom, and before and after mopping a resident's room. 18. Review of the provider's undated Handwashing/Hand Hygiene policy revealed, "This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections." Hand hygiene was to be performed after contact with items in a resident's room and after removing gloves.	F0880		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of	F0604	On 05-05-2026 the resident's onesie was discontinued to eliminate the restrictive intervention. The facility has no other restraints used An audit process was implemented by the MDS Nurse Coordinator to review all restraints and restrictive interventions quarterly to coincide with MDS assessment period to ensure continued assessment for less restrictive alternatives and potential discontinuation. Nursing staff were educated on restraint regulations, least restrictive measures, and ongoing assessment requirements at their monthly meeting on 05-13-2026 by the Therapy Director. The MDS nurse or designee will review residents with restrictive devices/interventions quarterly as followed by MDS assessment dates to ensure assessments and attempts at less restrictive measures are completed and documented. Findings will be reviewed during QAPI meetings for continued compliance.	05-13-2026

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F0604 SS = D	Continued from page 7 discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure there was documentation to support if one of one sampled resident (3) was a candidate for a restraint (a device, material, or medication used to restrict a resident's movement or access to their body to ensure safety or prevent harmful behavior) reduction, a less restrictive restraint method, or for a restraint elimination. Findings include: 1.Observation on 4/29/26 at 8:00 a.m. in the dining room revealed resident 3 was seated in his wheelchair. The staff provided him with verbal and physical assistance to eat his breakfast. He repetitively moved his feet and gently rocked his trunk forward and back. Resident 3 moved his hand in and out of the waistband of his sweatpants several times. 2. Observation on 4/29/26 at 1:00 p.m. of resident 3 in his room revealed he was awake and seated in his recliner. He placed his hand in and out of the waistband of his sweatpants repeatedly. 3. Review of resident 3's electronic medical record (EMR) revealed his 3/19/26 Brief Interview of Mental Status assessment score was 0. That score indicated he had severe cognitive impairment. His diagnoses included a history of a traumatic brain injury (a disruption in normal brain function caused by a bump, blow, jolt, or injury to the head) and dementia (a group of symptoms affecting memory, thinking, and social behavior) with behavioral disturbances. The resident was administered medications by his physician to manage his behavioral symptoms. An "Informed Consent For Use Of A One-Piece Garment" (a one-piece jumpsuit) was signed by resident 3's spouse on 2/6/24. The garment was identified as a restraint intervention, and the potential benefits and risks associated with the use of that garment were discussed with the resident's	F0604		

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F0604 SS = D	Continued from page 8 spouse. A 7/29/25 faxed communication from nursing staff to resident 3's physician stated "[Resident 3] continues to fondle himself and expose his genitals, as has been a continued concern. He has had multiple previous medication changes without resolution [of the behavior]. To enhance his dignity and to prevent exposure [of his genitals] to other residents and visitors, as this behavior is unable to be redirected or anticipated, may we have an order to use a onesie [a one-piece jumpsuit] as needed for the behavior of exposing himself?" The physician approved that request. Resident 3's 4/7/26 quarterly Minimum Data Set (MDS) assessment, section P, indicated the resident used a trunk restraint on a less- than daily basis. MDS nurse D's 4/7/26 MDS Quarterly Assessment note indicated, "[Resident 3's] spouse requested [the] use of adult adaptive clothing [a one-piece jumpsuit] in order to protect [resident 3's] dignity. When available [resident 3] will wear the one-piece [jumpsuit]." That Assessment did not include documentation that supported the continued use or discontinued use of that jumpsuit. There was no indication that other alternatives to the jumpsuit were tried. Resident 3's 3/30/26 through 4/29/26 behavioral tracking user-defined assessment (UDA) indicated that staff documented the daily frequency of the resident's targeted behaviors, which included kicking, pushing, scratching, grabbing, and abusing others sexually. Fondling and exposing his genitals were not identified as targeted behaviors on that UDA. Resident 3's revised 4/17/26 care plan focus area related to the use of the jumpsuit revealed, "[Resident 3] will frequently remove [his] private parts [genitals] from [his] pants and urinate and/or dig in [his] pants at inappropriate times. Behavior does not appear to be correlated to toileting schedule, as it occurs immediately after toileting and/or intermittently throughout day." Resident 3's spouse requested the use of one-piece jumpsuit to protect his dignity. "He [resident 3] has potential to smear bodily waste." 4. Interview on 4/29/26 at 2:50 p.m. with licensed	F0604		

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F0604 SS = D	Continued from page 9 practical nurse (LPN) H regarding resident 3's jumpsuit revealed the jumpsuit's zipper was on the backside of the garment, restricting the resident's access to his genitals. She stated resident 3 did not wear that jumpsuit "in a long, long time." He had declined physically and cognitively over the past few years. 5. Interview on 4/29/26 at 2:55 p.m. with certified nurse aide (CNA) I regarding resident 3 revealed she had worked at the facility for about six months and did not see the resident wear a one-piece jumpsuit. 6. Observation and interview on 4/29/26 at 3:00 p.m. with MDS nurse D in resident 3's room revealed that a one-piece jumpsuit was hanging in his closet. MDS nurse D used her interview with day shift staff to support her 4/7/26 Quarterly MDS Assessment progress note that indicated, "When available [resident 3] will wear the one-piece jumpsuit]." She did not know if the staff had completed any restraint-related documentation for resident. She had not known if the staff completed any restraint-related documentation for resident 3's jumpsuit use. She acknowledged that without that documentation, she did not know if the jumpsuit continued to be needed or it it could be discontinued. 7. Interview, EMR review, and review of the provider's revised April 2017 Use of Restraints policy on 4/30/26 at 10:00 a.m. with director of nursing (DON)/wound nurse B revealed she had not known if resident 3 was still wearing his one-piece jumpsuit. There was no restraint-specific form that staff were expected to use to document the dates and times when the jumpsuit was worn by resident 3, what precipitated his need to wear the jumpsuit, what less restrictive interventions (preventative approaches to mitigate the use of the jumpsuit), were tried before the jumpsuit was placed on the resident, or how long the jumpsuit was worn before it was able to be removed. She acknowledged that without that documentation, MDS nurse D was not able to comprehensively assess or make recommendations in her quarterly MDS progress note whether resident 3 continued need the jumpsuit or if the jumpsuit could be discontinued. Review of the provider's revised April 2017 Use of Restraints policy revealed, "When the use of restraints is indicated, the least restrictive alternative	F0604		

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F0604 SS = D	Continued from page 10 will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented." "Restrained individuals [residents] shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination."	F0604		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and job description review, the provider failed to adhere to nursing professional standards of practice for following a physician's order for one of one sampled resident (1) with physician's orders for a urology consultation for evaluation and care. Findings include: 1.Observation on 4/28/26 at 2:20 p.m. in resident 1's room revealed he was transferred from his wheelchair to his recliner by certified nurse aide (CNA)/registered medication aide (RMA) N and CNA/RMA O. The resident's Foley catheter (an indwelling tube inserted into the bladder to drain urine) urine collection bag was stored inside a cloth bag for dignity. 2. Review of resident 1's electronic medical record (EMR) revealed he was hospitalized from 1/6/26 through 1/13/26 for treatment of a left femur (thigh bone) fracture. A 1/8/26 urology progress note indicated the resident's Foley catheter was removed, and he was able to urinate. A 1/10/26 Discharge Disposition note from the hospital stated that a Foley catheter was placed on 1/10/26. The 1/13/26 Discharge to SNF (skilled nursing facility) form included an area for instructions regarding the removal of the Foley catheter, catheter care instructions, and the indication for the catheter, but that area was not completed. A 1/23/26 faxed communication from the provider's	F0658	On 04-28-2026 the ADON phoned the provider to check with the referral for urology. MRH Clinic nurse advised she was not aware he made recommendation. MRH clinic nurse phoned urology and set up appointment. Appointment was made for 05-19-2026. Nursing staff and management were educated regarding timely follow-up of physician orders and appointment scheduling at monthly meeting on 05-13-2026 by LNHA. An audit/follow-up tracking form was implemented on 05-12-2026 by the LNHA to be completed after physician rounds and receipt of physician orders to ensure all appointments, referrals, and follow-up orders are scheduled and completed timely. The DON, ADON or designee will audit physician orders and appointment follow-up weekly for 4 weeks, then monthly for 2 months or until substantial compliance is met. Findings will be reviewed through the QAPI process, with corrective action implemented as needed.	04-28-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435123	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walworth County Care Center, Inc	**4861 LINCOLN AVENUE , SELBY, South Dakota, 57472**

(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
F0658 SS = D	Continued from page 11 nursing staff to resident 1's physician asked about discontinuing the resident's Foley catheter. The physician's response was "Start Alfuzosin (a medication used to treat symptoms of enlarged prostate) 10 mg [milligrams] once daily for 4 days then attempt [a] trial without [the] catheter." On 1/30/26, the resident's physician was faxed a nursing communication indicating that a 1/29/26 trial removal of the resident's Foley catheter was not successful, and a catheter was re-inserted. The physician's response was "Restart Foley [catheter] and f/u [follow-up] with urology." Resident 1's February 2026, March 2026, and April 2026 physician's progress notes regarding his assessment of the resident's urinary retention indicated, "Referral to urology for further evaluation and care." Resident 1's 1/21/26 catheter care plan indicated the resident had a Foley catheter and included catheter care instructions. There was no mention of a plan for removing the Foley catheter. 3. Interview on 4/29/26 at 1:00 p.m. with licensed practical nurse (LPN) H regarding resident 1's urology consultation revealed she knew the resident was expected to be seen by a urologist, but did had not yet occur and she was not sure why. 4. Interview on 4/30/26 at 9:45 a.m. with director of nursing (DON)/wound nurse B and assistant director of nursing (ADON)/infection preventionist (IP) C regarding urology consultations revealed the resident's physician was expected to call a urologist to make that referral. The urology office would then call the facility to confirm the appointment time. ADON)/IP C was assigned to round (a process where healthcare staff, such as nurses and physicians, regularly visit residents to assess their needs, ensure safety, and improve care quality) with resident 1's physician during his monthly resident visits. The status of resident 1's urology consultation should have been discussed during those rounds. DON/wound nurse B and ADON/IP C revealed ADON/IP C recalled discussing the urology consultation with resident 1's physician during his January 2026 rounds. It was ADON/IP C's understanding that the physician would call the	F0658		

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	435123	A. BUILDING B. WING	**04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0658 SS = D	Continued from page 12 urologist to make the referral. ADON/IP C confirmed during the February 2026, March 2026, and April 2026 rounds that she did not discuss the status of resident 1's urology consultation with the physician. At no other time outside of the monthly rounds had she spoken with resident 1's physician about the urology consultation. DON/wound nurse B acknowledged the failure to follow the January 2026 physician-ordered urology consultation for resident 1 was "100% on us [the facility.]" 5. Review of the undated Registered Nurse (RN) job description revealed duties and responsibilities include "Assist in developing methods for coordinating nursing services with other resident services to ensure the continuity of the residents' total regimen of care."	F0658	Type text here	
F0686 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 observation, interview, record review, and policy review, the provider failed to assess, document, and notify the resident's physician of two facility-acquired pressure ulcers (skin and/or underlying tissue injury from prolonged pressure) for one of one sampled resident (12) who developed a pressure ulcer on her right heel and left buttock, and to complete wound assessment documentation weekly for her right inner buttock pressure ulcer by	F0686	ADON and DON were notified of pressure ulcer area on 04-30-2026. Physician was notified on 05-01 of pressure ulcer to right heel. ADON put interventions (heel protector applied to right heel, education to elevate and float heels when sitting idle or when lying in bed and encouraged only to wear shoe on right foot with transfers) into place. Documentation was included on 04-30-2026. On 05-11-2026, the DON contacted PointClickCare (PCC) and after lengthy Process, PCC was able to update the title of the wound documentation assessment from "daily" to "weekly" to align with facility policy and practice. Change was made to reflect the correct assessment title 05-14-2026. DON will review 24 hour report daily for updates on skin conditions. On 05-18-2026, DON educated/notified all charge nurses via hot charting as a way to reach all nurses, on the chain of command to diagnose pressure ulcer. When skin concern is noticed, CNA will inform charge nurse of concern and charge nurse will perform initial skin assessment and contact DON with results of skin assessment. DON will follow up and notify provider of concerns. Nursing staff were also updated and educated on 05-13-2026 by DON on the facility's wound documentation policy and required documentation frequency. The DON/designee will audit wound documentation weekly for 4 weeks, then monthly for 2 months to ensure documentation is completed per policy. Findings will be reviewed through the QAPI process and additional education provided as needed.	05-18-2026

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F0686 SS = D	Continued from page 13 one of one director of nursing (DON)/wound nurse B and for nursing staff to monitor her right and left inner buttocks daily. Findings include: 1. Observation and interview on 4/28/26 at 2:39 p.m. with resident 12 in her room revealed she was sitting on a Roho pressure-relief cushion in her wheelchair, and she stated she had an open sore on her bottom. 2. Interview on 4/29/26 at 1:10 p.m. with certified nursing aide (CNA) M revealed resident 12 had a pressure sore on her bottom, and CNA M found a pressure sore on the resident's right heel yesterday (4/28/26) that was boggy (texture that is soft or spongy), and dark red and purple in color. 3. Interview on 4/29/26 at 1:22 p.m. with licensed practical nurse (LPN) H revealed that resident 12 had a stage II pressure ulcer (2; open wound or blister with partial-thickness skin loss) to her right and left inner buttocks, and yesterday (4/28/26), a new pressure ulcer was found on her right heel. LPN H notified DON/wound nurse B, who would then notify resident 12's physician. 4. Interview on 4/30/26 at 8:05 a.m. with DON/wound nurse B revealed that nurses were to complete weekly skin assessments on all residents, and they did not monitor pressure ulcers daily. DON/wound nurse B would measure and assess the residents' pressure ulcers weekly. The CNAs applied the non-medicated barrier cream to resident 12's buttocks and pressure ulcer when they assisted her to use the bathroom. The residents' physician would assess the residents' pressure ulcers when he rounded (a visit where a doctor goes from room to room to check on every patient under their care) monthly at the facility. He had not rounded since she had been back from the hospital. 5. Observation and interview on 4/30/26 at 9:37 a.m. of registered nurse (RN) K and CNA L while assisting resident 12 to the bathroom revealed she had an open stage II pressure ulcer to her right and left inner buttocks. CNA L applied a silicone barrier cream to her pressure ulcer and the rest of her buttocks, which was to be applied by the CNA staff every time resident 12 was assisted in the bathroom.	F0686		

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F0686 SS = D	Continued from page 14 Resident 12 had an unstageable pressure ulcer on her right heel that was dry, intact, and purple. 6. Interview on 4/30/26 at 9:53 a.m. with RN K revealed that nurses did not monitor pressure ulcers daily, and they were to assess and document the resident's pressure ulcers weekly when they completed the weekly skin observation. 7. Interview on 4/30/26 at 10:00 a.m. with assistant director of nursing (ADON)/infection preventionist (IP) C revealed that nurses did not monitor pressure ulcers daily, CNAs were to notify the nurse if a resident's wound was worsening, and verified that CNAs could not assess a pressure ulcer. 8. Review of resident 12's electronic medical record (EMR) revealed she admitted back to the facility from the hospital on 3/30/26. Her 4/17/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included a fracture of her pelvis and weakness. She had a 4/6/26 physician's order to use a Roho pressure-relief cushion in her wheelchair. Resident 12's 4/6/26 wound assessment completed by DON/wound nurse B, indicated her pressure ulcer to her right inner buttocks was identified on 4/6/26, it was a stage II pressure ulcer and measured: length was 2.8 centimeters (cm), width was 1.5 cm, and depth was 0.1 cm. There was no drainage, and it was pink in color. The wound assessment directed "daily documentation is required on pressure ulcers". On 4/9/26, her skin observation was documented as completed by LPN H and indicated she had a stage II pressure ulcer to her coccyx (tailbone) that measured 2 cm (length) by 2 cm (width). On 4/10/26, her wound assessment was completed by DON/wound nurse B, indicated her right inner buttocks pressure ulcer measured: length 2.8cm, width 1.5 cm, depth 0.1 cm. There was no drainage, and it was pink in color. On 4/16/26, her skin observation was documented as completed by LPN P and stated, "Stage II right	F0686		

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NAME OF PROVIDER OR SUPPLIER: Walworth County Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 4861 LINCOLN AVENUE , SELBY, South Dakota, 57472	

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F0686 SS = D	Continued from page 15 inner buttocks. Barrier cream applied. Lotion applied to extremities." On 4/23/26, her skin observation was documented as completed by LPN H and stated, "pink under both breasts, pressure are[a] persists to buttock, barrier cream applied." On 4/27/26, her wound assessment was completed by DON/wound nurse B, indicated her right inner buttocks pressure ulcer measured: length 2.5 cm, width 1cm, depth 0.1 cm. There was no drainage, and it was pink in color. On 4/27/26, her wound assessment was completed by DON/wound nurse B, indicated she had a stage II pressure ulcer identified on her left inner buttocks that measured: length 3 cm, width 1 cm, depth 0.1 cm. There was no drainage, and it was pink in color. Her 4/28/26 care plan indicated she had a pressure ulcer to her left and right inner buttocks, and staff members were to administer treatments as ordered by the physician and observe for their effectiveness. 9. Interview and EMR review on 4/30/26 at 11:39 a.m. with DON/wound nurse B revealed resident 12 had a pressure ulcer to her right and left inner buttocks. DON/wound nurse B was not aware that resident 12 developed a pressure ulcer on her right heel. DON/wound nurse B reviewed resident 12's EMR and could not find any documentation of the pressure ulcer on her right heel or that the physician was notified. She stated that the staff "typically" notified her when a new pressure ulcer was found, and she followed up (to take further action, investigate, or check on a previous matter to ensure progress, or reinforce initial action) on it. The nurse was to notify the physician of any new pressure ulcers. The current treatment for resident 12's pressure ulcer on her right and left inner buttocks was applying a protective barrier cream and using a Roho pressure-relief cushion in her wheelchair. She felt she notified resident 12's physician when resident 12's stage II pressure ulcer was first identified on 4/6/26 to her right inner buttock by	F0686		

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F0686 SS = D	Continued from page 16 requesting a physician's order for the Roho pressure relief cushion and indicated it was for her pressure ulcer on her buttocks. She did not notify the physician when her stage II pressure ulcer on her left inner buttock was identified on 4/27/26. She stated she was going to notify him when he was at the facility on 5/12/2026. 10. Review of the provider's undated Pressure Ulcers/Skin Breakdown Clinical Protocol policy revealed that the nurse was to document and report the pressure ulcer, but it did not indicate how often it should be done or who it was to be reported to. "The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings..., and applications of topical agents." "The physician will help identify medical interventions related to wound management...." "The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions." 11. Review of the provider's February 2021 Change in a Resident's Condition or Status policy revealed the nurse was to notify a resident's physician within twenty-four hours when a resident has a significant change of condition. The policy defined significant change of condition as "a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self-limiting'),... and it requires interdisciplinary [a group of experts from different fields] review and/or revision to the care plan [personalized plan that addresses a resident's care needs, goals, and interventions]".	F0686	Type text here	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	The resident transfer process was reviewed with involved staff on 04-29-2026. Staff were educated regarding use of gait belts, following transfer policies, and adhering to resident care plans during transfers by ADON.	

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F0689 SS = D	Continued from page 17 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 the safety of one of one sampled resident (11) who was observed not being transferred according to the resident's identified transfer assistance needs by one of one certified nurse aide (CNA) F and one of one CNA/registered medication aide (RMA) E which put the resident at risk for falling and sustaining an injury. Findings include: 1.Observation on 4/28/26 at 5:20 p.m. in the dining room revealed resident 11 was heard calling out to the staff, "Come here, come here." She had finished eating her evening meal. CNA F and CNA/RMA E approached the resident. They each placed one of their arms beneath the resident's underarms, lifted the resident from her dining room chair to a standing position, pivoted the resident, and lowered her onto her wheelchair seat. Continued observation and interview with CNA F revealed that she transported resident 11 to her room. CNA F placed her arms beneath the resident's underarms, lifted her from her wheelchair seat to a standing position, pivoted the resident, and lowered her onto a recliner. CNA F stated the resident was unable to bear her full weight on her feet to stand on her own. That was why she physically lifted resident 11 to a standing position. CNA F did not use a gait belt (a waist strap gripped as support for safe mobility and transfers) to transfer resident 11 because "She's [resident 11] too tiny." CNA F only used a gait belt to transfer larger, male residents. 2. Observation and interview on 4/29/26 at 9:00 a.m. with CNA/RMA G in resident 11's room revealed CNA/RMA G used a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) to transfer resident 11 from her	F0689	DON, ADON and MDS nurse reviewed all resident transfer care plans and gait belt use on 05-08-26 to ensure appropriate interventions were in place and followed. All care plans were updated as appropriate. On 05-13-2026 all nursing staff were re-educated on the gait belt policy, transfer policy, and the importance of following individualized resident care plans by ADON. Staff were instructed on reviewing and following resident care plans prior to transfers and assistance with mobility. The ADON or designee will complete random transfer and gait belt observation 10 audits weekly for 4 weeks, then 6 audits weekly for 4 weeks and the 3 audits weekly for 4 weeks or until substantial compliance is achieved. Findings will be reviewed during monthly QAPI meetings, and additional education or corrective action will be implemented as needed.	05-13-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435123	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0689 SS = D	Continued from page 18 wheelchair to the toilet. CNA/RMA G referred to the Kardex (a report of the resident's care needs and interventions) to know that resident 11 was to be transferred using a mechanical lift. 3. Review of resident 11's electronic medical record (EMR) revealed her Brief Interview for Mental Status assessment score was one, which indicated her cognition was severely impaired. Her 3/19/26 Morse Fall assessment score was 30, which indicated had a moderate risk for falling. Resident 11's revised 3/31/26 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) related to her transfer needs indicated that resident 11 "usually requires dependent staff assistance with sit-to-stand transfers and with chair/bed-to-chair transfers. [Resident 11] requires [a] Hoyer lift [a full body lifting device used to assist from a seated to a standing position] with staff assist x 2 [assistance by two staff persons] for transfers when she is not placing her feet on the ground for a pivot transfer with gait belt and staff assist x 1-2 [assistance by one to two staff persons] or in the sit-to-stand lift." 4. Interview on 4/30/26 at 10:00 a.m. with director of nursing (DON)/wound nurse B regarding revealed that the therapy department assessed each resident's mobility and transfer needs. Their recommendations were added to be added to the resident's care plan. That care plan information was then transferred to the resident's Kardex so staff members knew how to care for the resident. DON/wound care nurse B acknowledged that resident 11 was improperly and unsafely transferred by CNA/RMA E and CNA F when they failed to follow the transfer recommendations identified in the resident's care plan and on the resident's Kardex. That failure placed resident 11 at risk for falling and injuring herself. She expected staff to follow care-planned interventions for the safe transfer of all residents.	F0689		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435123	A. BUILDING **01 - MAIN BUILD...** B. WING	**04/28/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 4/28/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Walworth County 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	Type text here	
K0324 SS = B 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:	K0324	On 4/28/2026, the LNHA contacted Dakota Hood Cleaning regarding the identified deficiency that the rooftop ventilator did not have a hinge kit installed, as noted on the kitchen hood exhaust duct cleaning report dated 04-14-2026. An estimate was received and signed on 04-29-2026. The hinge kit installation was completed on 05-07-2026.	

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
Trista Bates	LNHA	05-19-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER **Walworth County Care Center, Inc**		STREET ADDRESS, CITY, STATE, ZIP CODE **4861 LINCOLN AVENUE , SELBY, South Dakota, 57472**	

(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 = B Bldg. 01	Continued from page 1 Based on record review and interview, the provider failed to maintain the kitchen hood exhaust duct system as required. The rooftop ventilator was fixed in place and could not be moved to inspect or clean the duct. Findings include: 1. Record review on 4/28/26 at 2:20 p.m. revealed the kitchen hood exhaust duct cleaning report dated 4/14/26 noted the rooftop ventilator was fixed in place and did not have a hinge kit installed to allow inspection or cleaning of the hood exhaust ductwork. Interview with the administrator at the time of the record review confirmed that finding. The deficiency affected one of numerous requirements for the fire alarm system.	K0324		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435123**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/28/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walworth County Care Center, Inc	**4861 LINCOLN AVENUE , SELBY, South Dakota, 57472**

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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 4/28/26. Walworth County Care Center, Inc was found in compliance.	E0000		

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
Trista Bates	LNHA	05-19-2026

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
	10676	A. BUILDING: ______ B. WING ______	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALWORTH COUNTY CARE CENTER, INC	**4861 LINCOLN AVE SELBY, SD 57472**

(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 4/28/26 through 4/30/26. Walworth County Care Center, Inc was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Trista Bates	LNHA	05-19-2026