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

PRINTED: 08/23/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		STRUCTION		(X3) DATE SURVEY COMPLETED	
435123		B. WING	B. WING			08/16/2023		
	ROVIDER OR SUPPLIER  TH COUNTY CARE CEN	TER, INC	•	4861 L	T ADDRESS, CITY, STATE, ZIP CODE INCOLN AVENUE Y, SD 57472			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	A recertification healt with 42 CFR Part 483 for Long Term Care fa 8/14/23 through 8/16/Center, Inc was found	h survey for compliance , Subpart B, requirements acilities was conducted from 23. Walworth County Care	F	000	TITLE		(X6) DATE	
Trist	Trista Bates				LNHA	C	08-24-2023	

Any reliciency statement enriging 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 districtions 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 musing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiences are cited, an approved plan of correction is requisite to continued

Event ID: YZXF11

program participation.

AUG 2 4 2023

Facility ID: 0102

If continuation sheet Page 1 of 1

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

PRINTED: 08/23/2023 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(V2) MIJIT	IPLE CONSTRUCTION		O. 0938-038
1, 7		IDENTIFICATION NUMBER:		NG	(X3) DATE SURVEY COMPLETED	
		435123	B. WING_		08	/16/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
WALWOR	TH COUNTY CARE CEN	TER, INC		4861 LINCOLN AVENUE		
	1			SELBY, SD 57472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
E 000	Initial Comments		ΕO	00		
	CFR Part 482, Subpa Emergency Prepared Term Care facilities w	ey for compliance with 42 rt B, Subsection 483.73, ness, requirements for Long as conducted from 8/14/23 worth County Care Center, poliance.				
				5.		
ABORATORY DI	RECTOR'S OR PROVIDER/SU	PPLIER REPRESENTATIVE'S SIGNATURE		TITLE	()	X6) DATE
	Trista Bates			LNHA		8-24-2023
· merce				LINI IA		

Any deliciency statement ending with an asterisk or dericing which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient propertion the patients. Sea just retions 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 previded. 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. For example, an approved plan of correction is requisite to continued program participation.

AUG 2 4 2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YZX F11

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Facility ID: 0102

If continuation sheet Page 1 of 1

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

PRINTED: 08/23/2023 FORM APPROVED OMB NO. 0938-0391

435123 B. WING	OTDEET ADDRESS OUTVICTATE 7/D CODE	08/15/2023		
	OTDEET ADDRESS SITY STATE 710 CODE	00/10/2020		
NAME OF PROVIDER OR SUPPLIER  WALWORTH COUNTY CARE CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE  4861 LINCOLN AVENUE  SELBY, SD 57472			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE DATE		
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Trista Bates	TITLE LNHA	(X6) DATE 08-24-2023		

Any deficiency statement ending with an estensk (Bendes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. See instructional Except or 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.

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YZXF21

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Facility ID: 0102

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South Dakota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10676		A. BUILDING:			COMPLETED 08/16/2023	
WALWOR'	TH COUNTY CARE CEN	TER. INC	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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BE APPROPRIATE	(X5) COMPLETE DATE
S 000	44:73, Nursing Facilit	compliance with the of South Dakota, Article ies, was conducted from 23. Walworth County Care	S 000			
	44:74, Nurse Aide, rettraining programs, wa	compliance with the of South Dakota, Article quirements for nurse aide s conducted from 8/14/23 worth County Care Center,	S 000			
BORATORY DI	RECTOR'S OR PHOVIDER/SI	JPPLIER REPRESENTATIVE'S SIGNATURI	=	TITLE		(X6) DATE

**LNHA** 

Trista Bates
STATE FORM

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