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
	435123	A. BUILDING _____ B. WING _____	03/24/2022

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

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F 000	INITIAL COMMENTS Surveyor: 41895 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/22/22 through 3/24/22. Walworth County Care Center, Inc was found not in compliance with the following requirements: F658, F700, and F880.	F 000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission nor agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or/or executed in compliance with State and Federal Laws. The facility respectfully requests a desk review for compliance.	
F 658 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: Surveyor: 41895 Based on interview, record review, and policy review, the provider failed to ensure two of fifteen sampled residents (4 and 24) professional standards of practice were followed for insulin administration and response to low blood glucose levels. 1. Review of resident 24's medical record revealed: *She had been admitted on 1/31/22. *Her diagnoses included: type 2 diabetes mellitus with hyperglycemia, heart failure, chronic kidney disease, anemia, obesity, and long term use (current) of insulin. *Her 2/7/22 admission assessment showed a brief interview for mental status (BIMS) score of 14, indicating her cognition was intact. Interview on 3/24/22 at 11:25 a.m. with resident	F 658	Physician was informed of Resident #4 and #24 blood sugars and reported he did not expect to be immediately notified of resident blood sugars as long as remedied with eating and drinking. Provider provided directions on treatment exceptions as well as notification expectations. Treatment expectations include if blood sugar is less than 70 mg/dl but greater than 50 mg/dl give 8 oz of juice and recheck blood sugar in 30 minutes. After 30 minutes if blood sugar is less than 70 mg/dl repeat 8 oz of juice and recheck blood sugar in 30 minutes. If blood sugar continues to be less than 70 mg/dl after second recheck, notify on call provider. Policy updated to clarify on physician notification time. Physician will be notified on holding insulin. Nursing staff educated immediately of physician treatment and notification expectations. Further education also provided at nursing meeting on 04-05-2022. All diabetic residents that reside in the facility have potential to be affected.	04-13-2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Trista Bates

TITLE
LNHA

(X6) DATE
04-13-2022

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.

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F 658	Continued From page 1 24 revealed she: *Had some low blood sugars since being admitted. *Had been able to feel when her blood sugar was getting low and alert the staff. *Felt the staff responded quickly when she had a low blood glucose level by giving her some juice and something to eat. *Did have changes in her insulin dose since she was admitted. Review of resident 24's February 2022 medication administration record (MAR) revealed: *Her insulin detemir dose had been decreased three times. She had received: -38 units from 2/1/22 through 2/6/22. -36 units from 2/7/22 through 2/14/22. -32 units from 2/15/22 through 2/24/22. -18 units from 2/25/22 through 2/28/22. *Her scheduled Novolog insulin had been decreased two times. She had received: -7 units three times a day before meals from 2/1/22 through the morning dose on 2/3/22. -2 units three times a day from the evening dose on 2/3/22 through the noon dose on 2/7/22. *2 units daily prior to lunch from 2/8/22 through 2/26/22. *Another order for Novolog to be given per sliding scale [varies the dose of insulin based on blood glucose level] parameters. -The resident was to have her blood glucose level checked three times a day before meals and insulin administered as indicated by the scale. -On 2/6/22 at 11:00 a.m. her blood glucose level was 153 and she should have received Novolog 4 units per sliding scale. It was documented as "Other/See Nurse Notes." -There was not a nurses note documented on 2/6/22.	F 658		

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F 658	Continued From page 2 -On 2/18/22 at 4:00 p.m. her blood glucose level was 134 and she should have received Novolog 2 units per sliding scale. There was no documentation indicating it was administered. *She also had her blood glucose level done at bedtime. *An order for glucose gel to be administered for blood glucose level less than 70. -This was started on 2/9/22. -It had been administered on 2/23/22, 2/24/22, two times on 2/25/22, and on 2/28/22. *The scheduled Novolog was not administered on 2/8/22 or 2/22/22. The documentation indicated her blood glucose was within normal limits. *The scheduled Novolog was not administered on 2/5/22 at 11:00 a.m. and on 2/6/22 at 7:00 a.m. and at 11:00 a.m. The documentation indicated to see the nurses notes. -There were no nurses notes as to why these doses were not administered or notification of a physician. Review of resident 24's March 2022 MAR revealed on: *3/1/22 at 11:00 a.m. her blood glucose level was 291 and she should have received Novolog 12 units per sliding scale. It was documented as "Hold/See Nurse Notes." *3/2/22 at 11:00 a.m. her blood glucose level was 130 and she should have received Novolog 2 units per sliding scale. It was documented as "Other/See Nurse Notes." *3/4/22 at 4:00 p.m. there was no documentation of Novolog 6 units per sliding scale was administered for a blood glucose level of 206. *There had been no documentation in the nurses notes as to why these doses were not administered. *3/8/22 a list of blood sugars was to be faxed to	F 658		

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F 658	Continued From page 3	F 658		

physician C. It was documented as "Other/See Nurse Notes."
*There was not a nurses note regarding a fax to physician C.

Review of resident 24's blood glucose levels revealed on:
*2/2/22 at 7:00 a.m. it was 49.
*2/3/22 at 7:00 a.m. it was 60, at 11:00 a.m. it was 49, and at 4:00 p.m. it was 64.
*2/4/22 at 5:20 a.m. it was 43, at 5:48 a.m. it was 58, and at 7:00 a.m. it was 46.
*2/5/22 at 11:00 a.m. it was 68.
*2/6/22 at 7:00 a.m. it was 50.
*2/8/22 at 7:00 a.m. it was 52.
*2/9/22 at 7:00 a.m. it was 35.
*2/12/22 at 7:00 a.m. it was 64.
*2/13/22 at 7:00 a.m. it was 48.
*2/14/22 at 2:53 a.m. it was 50.
*2/15/22 at 7:00 a.m. it was 53.
*2/17/22 at 4:19 a.m. it was 47.
*2/20/22 at 7:00 a.m. it was 66.
*2/22/22 at 11:00 am. it was 50.
*2/23/22 at 7:00 a.m. it was 59.
*2/24/22 at 4:00 p.m. it was 63.
*2/25/22 at 3:10 a.m. it was 47, at 3:25 a.m. it was 46, and at 11:00 a.m. it was 65.
*2/27/22 at 7:00 a.m. it was 62.

Review of resident 24's nurses progress notes from 2/1/22 through 3/24/22 revealed on:
*2/2/22 at:
-12:30 a.m. she had a blood glucose level of 54 and was given 8 ounces of a breeze nutritional supplement and a peanut butter sandwich.
-1:04 a.m. her blood glucose level was 112.
--No documentation of physician notification.
*2/3/22 at 12:26 a.m. she had been woken up to check her blood glucose level because it had

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been low at bedtime.
*2/4/22 at 12:39 p.m. resident had refused her lunch. The nurse had offered substitutes and educated her on hypoglycemia.
*2/8/22 at 4:43 p.m. physician C had made rounds and reviewed blood glucose levels with staff.
*2/11/22 at 2:45 a.m. "Her FSBS [fingerstick blood sugar] continue to run low especially in the mornings; discussed nutrition/blood sugar stabilization. She had an HS [hour of sleep] snack and is also agreeable to having a snack (prefers a PB&J [peanut butter and jelly] sandwich) after she uses the bathroom between 0200-0300 to see if this helps maintain her blood sugar until breakfast time."
*2/12/22 at 9:14 a.m. her blood glucose had been 64 that morning and she did not eat well at breakfast. She was given an apple and a peanut butter and jelly sandwich. There was no physician notification or follow-up documentation.
*2/13/22 at 7:36 a.m. her blood glucose had been 48 and was given an Ensure supplement. There was no physician notification or follow-up documentation.
*2/14/22 3:14 a.m. her blood glucose level was 50 and was given a peanut butter sandwich and Breeze supplement. There was no physician notification or follow-up documentation.
*2/14/22 at 7:33 a.m. indicated blood glucose levels had been faxed to physician C for review. There was not follow-up documentation.
*2/15/22 at 12:18 a.m. indicated her "FSBS remain unstable. Discussed nutrition, encouraged a heart healthy snack prior to bed; she voiced understanding."
*2/15/22 at 9:18 a.m. her blood glucose level had been 53, she was given a cookie and Ensure supplement, then went to breakfast. There was

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F 658	Continued From page 5 no physician notification or follow-up documentation. *2/17/22 at 4:21 a.m. her blood glucose level was 47 and she was given a nutritional supplement and a peanut butter sandwich. There was no physician notification or follow-up documentation. *2/21/22 at 3:20 p.m. her blood glucose level was 65 and she was given a sandwich and milk. There was no physician notification or follow-up documentation. *2/22/22 at 12:21 p.m. her blood glucose levels for a week had been faxed to physician C. He reviewed the levels and made no changes to her medication. *2/25/22 at 7:38 a.m. her blood glucose levels from 2/11/22 through 2/25/22 had been faxed to physician C. There was no follow-up documentation. *2/28/22 at 1:57 p.m. her blood glucose level was 48 and she told the nurse she felt like it was low. She had been given a dose of glucose gel. *2/28/22 at 2:430 p.m. she was feeling better. Her blood glucose level was 92 and she had been given a snack. *3/1/22 at 10:59 a.m. education was provided to her about her blood glucose levels by director of nursing A. She had agreed to not throw her food away until nursing could look and see what she had eaten. *3/1/22 at 5:52 p.m. she had been refusing to eat supper and her insulin was held. There was no physician notification or follow-up documentation. Review of faxed communications for resident 49 between the provider and physician C revealed on: *2/3/22 a note was sent to notify him of low blood glucose levels that day along with a list of blood glucose levels.	F 658		

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F 658	Continued From page 6 -He had returned the note with new orders to decrease her insulin and to fax her blood glucose levels again the following Monday. *2/9/22 to let him know of a blood glucose level of 35 and that they had administered glucose gel from their emergency kit. Had also asked for an order for the glucose gel. -He returned the fax with an order for the glucose gel as needed for a blood glucose level less than 70. *2/15/22 a list of blood glucose levels had been faxed to him. He returned the fax with new order to decrease the Levemir and fax blood sugars again, in one week. *2/25/22 a note indicated that her blood glucose levels continued to run low and a list of her blood glucose levels had been sent along with the note. -He faxed back with an order to decrease the Levemir and stop the scheduled dose of Novolog. *3/4/22 a list of blood glucose levels had been sent with no medication changes. Review of resident 49's Patient Visit Notes revealed: *Physician C had seen her on 2/8/22 and on 3/8/22. *He did discuss and review blood glucose levels and medications during each visit. Review of resident 49's 3/1/22 Care Conference Summary revealed: *She had been invited but chose not to attend. *Dietary, MDS (Minimum Data Set) nurse, activities, and social services had attended the conference. *Her blood glucose levels had not been addressed. *Her behavior to throwing food away before nursing could monitor what she had eaten had	F 658		

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F 658	Continued From page 7 not been discussed. Review of resident 49's revised 3/16/22 care plan revealed: *"[Resident's name] has potential to refuse to eat meals without reasoning given. She will indicate to nurse she is going to eat, insulin will be administered, and then refusal will occur. Education had been provided." *The goal was she would "be free from complications related to refusing food..." *Interventions included: -"Explain importance of consuming prescribed diet and/or risks of taking insulin and then refusing to eat, to [resident's name]. Educate on need for adequate nutritional intake." -"[Resident's name] triggers for refusing to eat are unclear at this time, will continue to monitor. [Resident's name] may indicate to staff she is upset, however does not provide reasoning/rationale. [Resident's name] behaviors are de-escalated by allowing time to self-calm, providing comfort and support." *It did not indicate what her blood glucose levels should be or what to do if they were low. 2. Review of resident 4's medical record revealed: *She was admitted on 8/2/21. *Her diagnoses included: chronic kidney disease, essential hypertension, dementia without behavioral disturbance, long-term (current) use of insulin, and type 2 diabetes mellitus with hypoglycemia without coma. *Her 1/24/22 quarterly assessment showed a BIMS of 4, indicating severe cognitive impairment. Review of resident 4's January 2022 MAR	F 658		

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revealed on:
*1/6/22 at 7:00 a.m. she was to have Novolog 5 units and it had been documented "Other/See Nurse Notes."
*1/8/21 at 4:00 p.m. her blood glucose level was 59.
*1/12/22 at 4:00 p.m. her blood glucose level was 62.
*1/17/22 at 9:00 p.m. her blood glucose level was 62.
*1/21/22 at 7:00 a.m. she was to have Novolog 5 units and it had been documented that her blood glucose level was within normal limits, so she did not need the scheduled dose.
*1/23/22 at 4:00 p.m. her blood glucose level was 49.
*1/25/22 at 7:40 p.m. her blood glucose level was 60.
*1/26/22 at 12:00 p.m. she was to have Novolog 3 units and it had been documented "Other/See Nurse Notes."

Review of resident 4's February 2022 MAR revealed on:
*2/2/22 at:
-7:00 a.m. her schedule Novolog 5 units was not given and it had been documented that her blood glucose level was within normal limits.
-4:00 p.m. she had a blood sugar of 66.
*2/16/21 at 8:17 p.m. she had a blood glucose level of 44.

Review of resident 4's March 2022 MAR revealed on:
*3/13/22 at 5:00 p.m. her blood glucose level was 54.
*3/18/22 at 12:00 p.m. her blood glucose level was 61.

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F 658	Continued From page 9 Review of resident 4's nurses progress notes revealed on: *1/10/22 at 3:11 p.m. her blood glucose level was 66 and she was given a peanut butter sandwich. There was no physician notification or follow-up documentation. *2/17/22 at 9:34 p.m. resident had a blood glucose level of 44 so a list of blood glucose levels had been faxed to physician's office. *2/18/22 at 1:30 p.m. physician had reviewed the blood glucose levels and gave no new orders. *3/13/22 at 4:39 p.m. her blood glucose level was 54 and she had been given peanut butter toast. Her blood glucose level was 99 within 20 minutes. 7:00 a.m. There had been no documentation the physician had been notified. *There were no other notes indicating the physician had been notified of low blood glucose readings. *There were no notes indicating to hold scheduled Novolog doses. Review of resident 4's revised 3/16/22 care plan revealed: *Her hospitalization prior to admission to the facility had been for severe hypoglycemia. *The goals included: -"[Resident's name] will have no complications related to diabetes..." -"[Resident's name] will be free from any s/sx [signs or symptoms] of hypoglycemia or hyperglycemia..." *Interventions included: -"Observe [resident's name] and document/report PRN [as needed] any s/sx of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait.	F 658		

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F 658	Continued From page 10 *It did not indicate what her blood glucose levels should be or what to do if they were low. 3. Interview on 3/24/22 at 1:26 p.m. with director of nursing B revealed: *She had considered a blood glucose level low if it was below 60. *If the resident had a blood glucose level below 60 and was alert she expected the nurse to give them juice or milk. *If the resident was not alert she would have expected the nurse to administer glucose gel or glucagon injection. *She did not expect the nurses to call a physician for a low blood glucose, just would expect them to give them some milk or juice. *If a resident was on scheduled insulin and sliding scale insulin even if the sliding scale insulin was not indicated she would expect the nurse to still administer the scheduled dose. *A nurse needed a physician's order to hold the insulin. *She had not reviewed the provider's policy for management of hypoglycemia and had not expected the nurses to follow it. *There was always a physician or nurse practitioner on-call. Interview on 3/24/22 at 4:00 p.m. with physician C revealed: *He does not have parameters set for blood glucose levels. *If a resident had a blood glucose level less than 80 he would expect a nurse to call and update him. *He expected nurses to treat a low blood glucose level with juice or crackers. *He was aware resident 24 had been refusing to eat at times.	F 658		

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F 658	Continued From page 11 *He felt like the provider was good at keeping him updated when a resident had a low blood glucose level. On 3/24/22 at 4:10 p.m. surveyors had requested documentation of education provided to nurses on diabetes and blood glucose levels and a physician notification policy from the administrator and director of nursing. They did not have any documentation of education or the policy. Interview on 3/24/22 at 4:20 p.m. regarding residents 4 and 24 with administrator A and director of nursing B revealed: *They did not have a standard of practice for guiding policy development. *They used policies written for them by Med Pass. *They used nursing judgement and if they had questions they would call a nurse consultant. Review of the provider's November 2020 Management of Hypoglycemia policy revealed for a blood sugar less than: *70 the nurse should have: -Given oral glucose. -Notified the doctor immediately. -Stayed with the resident. -Rechecked the blood sugar in fifteen minutes. *54 the nurse should have: -Given glucagon. -Notified the doctor immediately. -Stayed with the resident. -Make the resident comfortable. -Monitor vital signs. -Rechecked the blood sugar in fifteen minutes.	F 658		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435123	A. BUILDING _____ B. WING _____	03/24/2022

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

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F 700	Continued From page 12 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure two of two residents had: *Received risks versus benefits education for side rail use. *Obtained signed informed consent forms for side rail use. *Quarterly assistive device assessments completed. *Routine inspections of side rails. Findings include: 1. Observation and interview on 3/22/22 at 9:04	F 700	Resident #38 reported he uses grab bar to assist turning in bed. Resident #38 and resident representative were notified on grab bar risks and benefits on 03-23-2022 and physician order was in place on 03-24-2022. Resident #21 was assessed and determined grab bar was not appropriate on 03-23-2022. Grab bar was removed on 03-23-2022. For a resident needing grab bar enablers, the facility will ensure an assessment for entrapment risk prior to installation, risk and benefits of grab bar/enablers with resident and/or resident representative, ensure correct installation and maintenance. Physical Therapy Director/Designee will also ensure signed consent and physician order is in place. Prior to installation of grab bar/enablers, appropriate alternatives will be discussed by appropriate members of IDT. Assessments will be completed quarterly, as well as routine inspection and maintenance. All unoccupied beds grab bars were removed to avoid inadvertently placing a new admission with grab bar in place. Grab bar assessments will also be completed on new admissions. The facility determined the possibility exists that other residents could be affected at risk for grab bar risks. Physical Therapy Director/Designee will be responsible for grab bar assessments. Residents who reside in the facility have potential to be affected by this alleged finding.	04-13-2022

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F 700	Continued From page 13 a.m. with resident 38 revealed: *He had been in his room, sitting in a wheelchair and watching television. *He thought he was here to see "patients". *His bed had a side rail attached on the right side. -This side rail was in the up position. *He stated he used the side rail to help him turn over in bed. Review of resident 38's medical record revealed: *He had been admitted on 2/5/22. *His diagnosis included: Fracture of his left femur and dementia. *There was no documentation that a safety assessment had been completed for use of a side rail. *There was no documentation that education of risks versus benefits had been completed. *There was no documentation that informed consent had been given. Interview on 3/23/22 at 2:45 p.m. with director of nursing (DON) B revealed: *She thought a therapist completed safety assessments for side rails. *Resident 38 used the right side-rail as a "grab bar". Interview on 3/23/22 at 2:48 p.m. with DON B and director of therapy-physical therapist (PT) K revealed: *The process for use of side rails was: *PT K would complete an informal assessment when a resident is admitted. -If she thought the resident would participate better in transferring with a side rail, she would recommend the use of it. *PT K stated resident 38 needed physical assistance of two people and a side rail for	F 700		

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F 700	Continued From page 14 positioning while in bed. -The side rail should be used only for bed positioning. Surveyor: 41895 Observation and interview on 3/22/22 at 4:10 p.m. of resident 21 sitting on the edge of the bed with her daughter revealed: *The daughter had indicated that her mother's memory was not good and she could not remember things. *The bed had a side rail attached to the right side in the up position. *The daughter did not know why she had it, and had not been told why she needed it. Review of resident 21's 8/17/21, 11/8/21, and 1/31/22 Positioning Device/Restraint Assessments revealed they had not: *Included the side rail. *Included consent or education of the side rail. *Addressed the risk for entrapment. Review of resident 21's medical record did not include a signed consent for use of a side rail. Review of resident 21's 3/16/22 care plan revealed the side rail had not been part of the care plan. Interview on 3/23/22 at 5:03 p.m. with maintenance director D revealed: *He did not have documentation that the side rails are inspected regularly. *He had planned to start documenting when he inspected the rails.	F 700		

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F 700	Continued From page 15 Interview on 3/24/22 at 1:20 p.m. with director of nursing B regarding use of side rails revealed: *Therapy did the assessment for use of the side rails. They did not document that assessment. *She had been aware of what was required for use of the side rails. *They had contacted families and had started to get consents signed for use of the side rails. Review of the provider's December 2016 Proper Use of Side Rails policy revealed: *"3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: -a. Bed Mobility; -b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet' -c. Risk of entrapment from the use of side rails; and -d. That the bed's dimensions are appropriate for the resident's size and weight. *4. The use of side rails as an assistive device will be addressed in the resident care plan. *5. Consent for using restrictive devises will be obtained from the resident or legal representative per facility protocol." *"8. The risks and benefits of side rails will be considered for each resident." *There was a hand written statement on the bottom of the policy that stated "The [name of facility] does not use bed rails. Grab bars are used to promote resident independence with rolling, scooting, and sit to/from lying transfers when needed."	F 700		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 16 §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 §483.70(e) 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:	F 880	It is a policy of the facility to have a system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. Results will be submitted through the QA/QAPI process for review/ recommendations. Any patterns will be identified. If necessary, an Action Plan will be written by the IDT and monitored by the Administrator weekly until resolved. Education was provided immediately by DON at all staff center chat on 03-22-2022. Hand Hygiene education and audit was completed at all staff meeting on 04-05-2022. All staff were provided training videos provided by CMS to include cleaned hands and PPE usage. Policy/re-education about roles and responsibilities for the identified assigned care and service tasks was provided by DON on 04-05-2022. Licensed staff were educated on proper hygiene with wound care on 04-05-2022. All residents and staff have the potential to be affected by the lack of appropriate hand hygiene by licenses staff during performance of wound care, appropriate handling of wound care supplies and appropriate N95 doffing and donning a face mask. Root cause analysis (RCA) reviewed and collected data regarding infection control practices, to provide action on donning and doffing N95 mask. Team members involved included Administrator, DON, ADON, Floor Nurse and CNA. CNA had N95 mask on and entered resident room that was in isolation to perform cares. Upon completion of cares, she removed N95 and discarded in trash. She obtained a new surgical mask from PPE cart and put that mask on and did not complete hand hygiene before getting surgical mask. CNA voiced understanding that she should have used hand sanitizer.	04-13-2022

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F 880	Continued From page 17 (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: Surveyor: 45095 Based on observation, interview, and policy review, the provider failed to ensure: *One of one registered nurse (RN) F had completed appropriate hand hygiene (HH) during wound care for one of one sampled resident (32). *One of one certified nursing assistant (CNA) had completed appropriate HH when doffing an N95 and donning a face mask for one of one random observation.	F 880	Best practice is to have alcohol-based hand sanitizer located on the PPE cart, however we have a resident who wanders and was taking the hand sanitizer and attempting to drink, so all hand sanitizer was moved out of visual range. This move could have contributed to the miss stepped of using hand sanitizer between mask change. CNA was educated on 03-25-2022 by DON. Signs will be posted as a visual reminder for staff. Root cause analysis (RCA) reviewed and collected data regarding infection control practices, to provide action on appropriate handling of wound care supplies. RN followed wound care procedure correctly, however she missed opportunity for hand hygiene during the wound care. She removed her gloves after the procedure and did not wash or hand sanitize before applying clean gloves. RN voiced understanding of the missed opportunity to perform hand hygiene and was consequently terminated due to performance. Administrator contacted Quality Improvement Advisor with Great Plains Quality Innovation Network was conducted on 04-07-2022 regarding the Directed Plan of Correction for the recent SD DOH Survey. Coordinator stated, "it appears you have a good understanding of quality improvement methodology and have already begun your mitigation efforts in addressing issues". Infection control and prevention resources were also provided. ADON/Designee will conduct auditing and monitoring 2-3 times/weekly over all shifts to ensure identified and assigned tasks are being completed as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. Staff compliance in donning doffing N95 and handling wound care supplies. Any other areas identified through RCA. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring for 3 months. Monitoring results will be reported by ADON/Designee to QAPI team and continued until compliance as determined by QAPI team. We currently have no wound care in facility but will conduct verbal audit twice month and get active care will audit during wound care with next resident with wound care for compliance.	

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F 880	Continued From page 18 1. Observation and interview on 03/23/22 at 11:35 a.m. of licensed practical nurse (LPN) E and registered nurse (RN) F completing resident 32's wound care revealed: *A physician order for wound care was in the electronic medical record. -"Twice a day remove packing, rinse with half strength H2O2 [hydrogen peroxide]. Rinse with saline. Use 2 inch Kling roll and pack wound with dry dressing pack under all skin flaps and in abscess cavity. When Kling is in place, sprinkle with betadine. Cover with dry sterile dressings after that. Two times a day for wound care." *Nursing had followed the wound care procedure per physician order correctly. *RN F missed one of three opportunities' for handwashing during the wound care. -She had removed her gloves after she completed cleansing the wound and had not washed her hands or used hand sanitizer before she had applied clean gloves to place a new dressing. Interview on 3/23/22 at 2:20 p.m. with RN F regarding resident 32's wound care and infection control revealed; *Hand hygiene and glove changes should have occurred when moving from dirty to clean during wound care. *RN F agreed she had missed an opportunity for hand hygiene prior to putting on clean gloves to place a clean dressing. Review of the facility's August 2019 Handwashing/Hand Hygiene policy revealed; *"2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors."	F 880		

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F 880	Continued From page 19 *"7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:" -"Before moving from a contaminated body site to a clean body site during resident care." *"Procedure" -"Applying and Removing Gloves" --"1. Perform hand hygiene before applying non-sterile gloves." Surveyor: 43844 2. Interview and observation on 3/23/22 at 8:40 a.m. with CNA L revealed she: *Had come from a resident room after performing personal cares. *Had an N95 mask on, which would have been contaminated. *Removed the contaminated N95 mask and discarded it in a trash can. *Obtained a new surgical mask from a personal protective equipment cart and put it on. *Did not complete HH when she removed the contaminated N95 and before obtaining the new surgical mask. *Agreed she had not completed HH and should have. -Had training in the last year regarding proper HH. Interview on 3/23/22 at 9:45 a.m. with administrator A and director of nursing B revealed: *Administrator A agreed HH should have been completed when removing an N95 as it would have been contaminated. *Administrator A and director of nursing B both would have expected to have HH completed each time gloves were removed.	F 880		

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F 880	Continued From page 20 Interview on 3/23/22 at 2:58 p.m. with director of nursing B regarding HH revealed: *Her expectation was for staff to complete HH between: -Removing contaminated gloves and donning new gloves. -After removing gloves. -Removing a contaminated mask and a new mask. *Training had been for HH had been provided annually and upon hire. -Reminders of proper HH had been provided during stand-up meetings each day. *The infection control nurse and director of nursing completed random audits for HH on a continual basis. Review of provider's undated validation checklist for donning/removing personal protective equipment (PPE) revealed: *11. Goggles/face shield are removed from the sides or front..... 12. Hand hygiene performed with alcohol-based hand sanitizer. 13. Mask/respirator is removed..... 14. Hand hygiene performed with alcohol-based sanitizer paying attention to hands and forearms." Review of provider's April 2020 general procedure for donning and doffing masks revealed: *"1. To put on a mask: a. When donning the face mask, do so immediately after hand hygiene." -"d. After touching a facemask or before changing a face mask, perform hand hygiene." *"2. To remove mask: a. Front of mask is contaminated-DO NOT TOUCH. If your hands get contaminated during	F 880		

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F 880	Continued From page 21 mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer.	F 880		

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E 000	Initial Comments Surveyor: 41895 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 from 3/22/22 through 3/24/22. Walworth County Care Center, Inc was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Trista Bates
TITLE: LNHA
(X6) DATE: 04-13-2022

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.

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	435123	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/23/2022**

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/23/22. Walworth County Care Center, Inc was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Trista Bates

TITLE
LNHA

(X6) DATE
04-13-2022

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 ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435123	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**3/23/2022**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items and oxygen concentrators were stored within five feet of the oxygen cylinders. Findings include: 1. Observation on 3/23/22 at 11:00 a.m. revealed combustible materials were found to be stored adjacent to and within five feet of oxygen cylinders. The minimum five feet of separation between combustibles and oxygen storage was not maintained as required in this area. The deficiency affected one of four smoke compartments.

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

The above isolated deficiencies pose no actual harm to the residents

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 _____	03/24/2022

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

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S 000	Compliance/Noncompliance Statement Surveyor: 43844 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/22/22 through 3/24/22. Walworth County Care Center, Inc. was found not in compliance with the following requirements: S210 and S236.	S 000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission nor agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or/or executed in compliance with State Laws. The facility respectfully requests a desk review for compliance. S 210 Employee Health Program Unable to correct prior non-compliance with staff member F,G, H, I, J. Education occurred to remind Human Resources Director (HR) to ensures new hire employee health screens are evaluated and signed by licensed health professional (DON, ADON, PT) within 14 days of hire. HR will keep track of this requirement routinely. A monitoring tool will be implemented to assist with this requirement. This will be monitored for the next six new hires for six months and then random monitoring will occur. HR will work together with the DON to ensure this practice does not continue. All information will be brought to monthly QA to ensure substantial compliance is met.	04-13-2022
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43844 Based on record review, interview, and procedure review, the provider failed to ensure five of five recently hired sampled employees (F, G, H, I, and J) had a health evaluation by a licensed health professional completed within fourteen days of	S 210		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Trista Bates — TITLE: LNHA — (X6) DATE: 04-13-2022

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S 210	Continued From page 1 being hired. Findings include: 1. Review of employee's personnel records revealed: *The following employees were hired on the following dates: *Employee F: 1/1/22. *Employee G: 12/29/21. *Employee H: 9/7/21. *Employee I: 2/8/21. *Employee J: 12/7/21. *The above employees' files had no evidence of health evaluations by a health care professional to determine they were free of communicable diseases. *These five employees health evaluation forms were signed by the employees themselves. Interview on 3/24/22 at 2:10 p.m. with Administrator A regarding employee health evaluations revealed: *The employee health evaluations had not been completed by a licensed health professional for the above employees.. *She was not aware these forms needed to be reviewed by a licensed health professional. *There was not a policy for health evaluation screenings. Interview on 3/24/22 at 2:22 PM with director of nursing B regarding employee health evaluations revealed she had not been aware of employees should have been evaluated for communicable diseases.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare	S 236		

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S 236	Continued From page 2 workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43844 Based on record review and interview, the provider failed to ensure two of five sampled employees (F and I) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of employee F's personnel file revealed: *She was hired on 1/1/22.	S 236	S 236 Tuberculin Screening Requirements Unable to correct prior non-compliance with staff member F, H and I's TB tests. Education occurred to remind the Infection control nurse of this regulation, all department heads are aware of the requirement and will ensure that their employees have the first skin test upon hire and then monitor for the 2nd step. The Human Resources Director (HR) will keep track of this requirement routinely. A monitoring tool will be implemented to assist with this requirement. This will be monitored for the next six new hires for six months and then random monitoring will occur. HR will work together with the DON to ensure this practice does not continue. All information will be brought to monthly QA to ensure substantial compliance is met.	04-13-2022

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S 236	Continued From page 3 *There was no record a TB skin test had been completed. Review of employee H's personnel file revealed: *She was hired on 2/8/21. *Her first TB skin test was administered on 2/8/21. *Her second TB skin test was not administered until 3/23/21, forty-three days after her date of hire. Interview on 3/4/22 at 1:08 p.m. with administrator A regarding TB skin tests revealed: *There was not a TB Screening for employee F. *She did not know why employee I's TB screen would not have been completed. *She would have expected any licensed nurse to have completed the TB screening. *There was no a policy for TB screening for employees. Interview on 03/24/22 at 2:18 p.m. with director of nursing B regarding TB skin tests revealed: *She was not certain why employee I's TB screen had not been completed within 14 days of hire. *She would have expected any licensed nurse to have completed the TB screening. *Their process was to give the employee a reminder card with the date of when their TB test was to be read. -It was the employee's responsibility to ensure their TB test was read. -The nurse who administered the TB test was to write the day it needed to be read in the appointment calendar.	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 41895	S 000		

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S 000	Continued From page 4 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/22/22 through 3/24/22. Walworth County Care Center, Inc was found in compliance.	S 000		