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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING _____ B. WING _____	09/01/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/30/21 through 9/1/21. Wilmot Care Center Inc was found not in compliance with the following requirements: F727, F812, and F838.	F 000	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483 35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, licensed nursing schedule review, and the Facility Assessment review, the provider failed to ensure: *There were eight hours of registered nurse (RN) coverage every twenty-four hours for nine of twenty eight days (8/2/21 through 8/29/21) *The director of nursing (DON) had worked as DON on a full time basis. Findings include:	F 727	F727 Waiver of requirement to use services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week was obtained on 9-13-2021. The Administrator will notify Residents and families of the waiver by 10-20-2021 and the waiver will be renewed/requested annually as needed. Administrator will provide nursing staff education regarding the nursing waiver by 10-20-2021. Facility will continue to recruit RNs to fill hours. Director of Nursing or designee will monitor staffing and resident appropriateness on a weekly basis and will report to QAPI on a monthly basis as long as waiver is in place.	10-20-2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Qaru Van Beek | TITLE: Administrator | (X6) DATE: 9-23-2021 / 10-6-2021

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 727	Continued From page 1	F 727		

1. Interview on 8/31/21 at 10:30 a.m. with administrator A regarding staffing concerns revealed:
*The provider was having difficulty finding and retaining RNs.
*The DON had left her position in Mid-July.
*Administrator A thought the provider had signed up for an RN waiver, but just found out the waiver had not been completed.
*Interim DON B had:
-Retired in July 2021.
-Returned as interim DON after DON E was no longer working there.
-Also been working as the Minimum Data Set Coordinator.
-Been working in the building twenty-four to thirty-two hours a week.
-Been available by phone when he had not been working in the building.
-Remote access to the electronic medical record from home.
*Two other RN's were filling in to help with RN coverage and with the MDS assessments.

Review of the 8/2/21 through 8/29/21 nursing schedule revealed:
*No RN coverage for the following dates: 8/14, 8/15, 8/18, 8/22, 8/23, 8/28, and 8/29.
*Four hours of RN coverage on 8/20.
*Six and one-half hours of RN coverage on 8/27.

Interview on 9/1/21 at 3:30 p.m. with administrator A confirmed:
*Interim DON B had not been working as a full time DON.
*The provider had not had a current nursing waiver in place.
*The facility was not providing at least eight hours

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F 727 Continued From page 2
of RN coverage every day.

Upon request for a nursing policy or DON job description the surveyor was not provided with further documentation.

F 812 Food Procurement,Store/Prepare/Serve-Sanitary
SS=D CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Surveyor: 43021
Based on observation, interview, and policy review, the provider failed to ensure:
*Accurate labelling and discarding of out-dated food supplies (above prep table, walk-in cooler, canned food storage, rack, and dry storage area) in one of one kitchen.
*Appropriate hand hygiene and changing of gloves used to prevent contamination in the

F 727 F812
1. All outdated and undated food was removed from the kitchen and storage rooms - including hot dogs, salami, swiss cheese, jellied cranberry sauce, soup mixes, cereal, dented can of sweet potatoes and pasta. 10-20-2021

All food will be dated when it is opened and be discarded within 3 days or as appropriate. Any food frozen will be labeled with date frozen and date taken out of freezer so it can be used appropriately. Certified Dietary Manager (CDM) will monitor labeling and dating.

Food moved to other containers will be labeled and dated appropriately. CDM will monitor labeling and dating.

Dietary policies will be reveiwed and updated yearly by the CDM, especially those policies related to food labeling, outdates, and disposal. Consultant Dietitian will review policies and changes as necessary.

CDM or designee will provide training to current staff on labeling and dating products, checking for out dates and discarding products by October 10, 2021. All new employees will receive this training during their hands-on orientation or within 1 week of starting. Consultant dietitian will review training and will monitor during her monthly review.

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F 812	Continued From page 3 handling of ready-to-eat foods during one of one meal service with one of one cook (C) in one of one kitchen. Findings include: 1. Observation on 8/31/21 at 8:30 a.m. revealed: *Above the prep table were four undated 1-gallon miracle whip containers with a different type of dry cereal stored in each container. *On a cart in the walk-in cooler an undated zip lock bag of what appeared to be sliced roast beef and three zip lock bags of leftover food items: -Hot dogs dated 8/27 -Salami package dated 4/2021 in a zip lock bag dated 8/20. -Swiss cheese dated 8/10. *On the canned food storage rack was a can of cut sweet potatoes, dented at the seal. *On a metal shelf in the dry food storage area: -A can of whole berry cranberry sauce dated 3/26/21. -Three cans of jellied cranberry sauce with dates of 9/22/20, 7/10/21, and 7/21/21. *On the wooden storage shelves in the dry food storage area: -A package of toasted oats cereal enclosed with twist tie that was not dated. -Four opened soup mix packets stored in individual zip lock packages with dates of 6/24/21; 6/29/21; 7/22/21; and 8/10/21. -Three opened packages of pasta that were stored in plastic bags that were undated. 2. Observation on 8/31/21 of the noon meal service revealed: *At 11:19 a.m. cook C kept the same pair of gloves on while completing the following food preparation tasks: -Opened fridge and took out a container of	F 812	F812 cont. Dietary Manager or designee will check for outdates, labeling and dating open products daily for 1 week, weekly for 1 month, every other week for 1 month and then monthly. Dietary Manager or designee will report on labeling, dating and discarding outdated items initially to the QAPI committee by the October meeting and then quarterly until committee decides completeness. 2. Cooks had immediate training on glove use and handwashing provided by the Dietary Manager on 9-2-2021. Current staff was given training by the Dietary Manager on correct usage of gloves and handwashing in the kitchen on 9-14-2021. On-going monthly department meetings or trainings will include various topics to keep staff up-to-date and reminded of proper kitchen procedures. Dietary Manager will review and update dietary department policies yearly, especially those relating to gloves usage and hand handwashing. JVB 10-6-21	

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F 812	Continued From page 4 leftover chicken alfredo. -Dished one serving of leftover chicken alfredo with serving utensil into blender and blended chicken alfredo. -Removed blended chicken alfredo from blender with serving utensil into bowl. -Opened microwave to place bowl of blended chicken alfredo inside and heated food. -Returned to serving line to cut hot dog in bun into four pieces, touched the bun with gloved hands. -Opened microwave and took out a bowl and placed on tray. -Touched another hot dog on bun to cut into four pieces. -Handled saucers and serving utensil to dish cut watermelon into saucers. -Touched a plate and serving utensils to prepare next plate. -Touched saucer and serving utensil to dish another saucer of cut watermelon. -Took off gloves and washed hands at 11:30 a.m. *At 11:31 a.m. cook C put on a clean pair of gloves and kept the same pair of gloves on while completing the following food preparation tasks: -Prepared a plate for service using four different serving scoops and handled a hot dog bun with one hand to open and placed a hot dog into the bun with tongs. -Went into a storage area to retrieve a can of soup. -Dished a saucer of cut watermelon, touched both the saucer and serving utensil. -Prepared another plate for service using four different serving scoops. -Retrieved a skillet by the handle and set on the stove top. -Opened a bag of bread and took out two pieces of bread. -Opened container of butter.	F 812	F 812 cont. Dietary Manager will provide dietary staff with a written department orientation program for new employees which will be completed, checked off and signed within 14 days of kitchen start. Dietary Manager will ensure this is completed. Cook C was given education/training on glove usage and hand washing on 9-2-2021 and again on 9-14-2021 with the Dietary Manager. Dietary Manager or designee will audit each staff member on shift for proper glove usage and proper handwashing daily for 1 week, then each staff member weekly for 1 month, every other week for 1 month and then monthly. Each staff member will also audit another staff member at least one time per month for one quarter. Dietary Manager or designee will report proper glove usage and handwashing to the QAPI committee at the October meeting and then quarterly until committee recommends completed. VVB 10-6-21	

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F 812	Continued From page 5	F 812		

-Held the sides of the bread and buttered.
-Picked up the buttered bread and carried it to the skillet.
-Placed the buttered bread on the skillet.
-Opened the fridge to get package of processed cheese slices.
-Unwrapped the cheese and placed two slices of cheese on the bread.
-Opened the fridge to place the unused processed cheese slices back into the fridge.
-Touched can of tomato soup to open and emptied into a bowl.
-Opened the microwave to open and placed a bowl of soup into microwave.
-Touched controls on microwave to heat bowl of soup
-Touched a paper towel to pick up two items off the floor and placed items in garbage container
-Took individually wrapped soda crackers from a container and placed on tray.
-Touched utensil to turnover cheese sandwich and placed on a plate.
-Held toasted cheese sandwich on plate and cut sandwich into two pieces.
-Held utensil and scooped cut watermelon into bowl.
-Prepared another plate of food using four different serving scoops.
-Handed plate to co-worker and leaned on serving counter with gloved hands.
-Picked up skillet by the handle and brought to dishwasher room.
-Returned to serving line and picked up two plates.
-Placed two hot dog buns on each plate.
-Opened each bun with gloved hand, placed hot dog on each bun.
-Placed gloved hands on serving counter.
-Took edge of plastic wrap from dispenser and

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F 812	Continued From page 6	F 812		

placed film over one plate.
-Handled dirty dishes and brought to dishwasher room.
-Removed gloves and washed her hands at 11:46 a.m.

3. Interview on 9/1/21 at 2:36 p.m. with dietary manager D revealed:
*The general rule for leftovers was 3 days.
*Luncheon meat was considered good until the expiration date on the package.
*The cook had touched may different surfaces with her gloved hands before handling ready-to-eat food.
*The cook had been hired approximately one year ago.
*There was no written dietary orientation program for new employees.
*The cook's dietary orientation training program was not documented.
*The dietary orientation training included when wearing gloves ready-to-eat food was the only thing touched.

4. Interview on 9/1/21 at 6:10 p.m. with dietary manager D revealed:
*Guidelines for food storage used to be posted, but were not currently posted.
*The Food Storage Policy reviewed on January 2007 was current policy.
*The Food Storage Policy needs to be updated.

5. Review of the provider's May 2005 Food Storage Policy that was reviewed on January 2007 revealed:
*"Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of build foods. All containers must be legibly and

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F 812	Continued From page 7 accurately labeled." ""Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before refrigerated. Leftover food is used within 48 hours or discarded."	F 812		
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F 838	**F838** The Facility Assessment will be reviewed and updated by October 20, 2021 by the Director of Nursing and the Administrator. COVID-19 will be added under the Infectious Diseases portion of the Resident Profile and be included in the staff Annual Training and competencies. Nursing waiver will be included in the Facility Assessment under 1.5 Other and training will be given to all staff on the Facility Assessment by 10-15-2021. The Director of Nursing or designee will review the Facility Assessment on a monthly basis for one quarter and then quarterly. The Director of Nursing or designee will report to the QAPI committee on the completeness of the Facility Assessment at the October meeting and quarterly thereafter until the committee recommends completeness. JVB 10-6-21	10-20-2021

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F 838	Continued From page 8	F 838		

(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Surveyor: 32332
Based on interview and the provider's Facility Assessment review, the provider failed to review and update the facility assessment at least annually. Findings include:

1. Review on 9/1/21 at 4:00 p.m. of the provider's 12/9/19 Facility Assessment revealed:

JVB 10-6-21

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F 838	Continued From page 9 *The assessment had an area that indicated the assessment had been initiated or updated. -Administrator A had signed that area on 12/9/19. *There were no other dates on the assessment to indicate it had been reviewed or updated after 12/9/19. *The infectious diseases section had not included COVID-19 as a possible concern. -The provider had experienced a COVID-19 outbreak in 2020. *Page one of the provider's facility assessment revealed: -"Requirement: Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents." -"The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies." Interview on 9/1/21 at 4:30 p.m. with administrator A regarding the facility assessment confirmed: *She had not reviewed or updated the assessment since December 2019, but should have. *The provider did not have a policy for reviewing the facility assessment annually.	F 838		

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E 000	Initial Comments Surveyor: 32332 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 8/31/21 through 9/1/21. Wilmot Care Center Inc was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cara VanBeek | TITLE: Administrator | (X6) DATE: 9-23-2021

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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	435119	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/31/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/31/21. Wilmot 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 K291 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 1. Observation on 8/31/2021 at 2:15 p.m. revealed the battery pack emergency light for the electric swithgear located in the electrical room off of the boiler room would not illuminate. Interview with the building manager at the time of the observation confirmed that finding. 2. Observation on 8/31/2021 at 2:20 p.m. revealed the battery pack emergency light for thegenerator located in the generator room would not illuminate. Interview with the building manager at the time of the observation confirmed that finding.	K 291	K291 Facilities Manager replaced battery pack in the Mechanical room. Battery pack for Generator Room Emergency light was ordered and will be replaced when it is received. Emergency lighting will be added to the monthly Maintenance assignment sheets to assure compliance on an on-going basis. Emergency lighting will be checked by the Facilities Manager or designee weekly for 1 month, every other week for 1 month and then monthly. Facility Manager will report emergency lighting audits to the QAPI committee on a quarterly basis until committee deems completed.	10-20-2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla nBeek | TITLE: Administrator | (X6) DATE: 9-23-2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/31/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 1 The deficiency affected two of numerous requirements for the emergency lighting system.	K 291		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10712	A. BUILDING: _____ B. WING _____	09/01/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/31/21 through 9/1/21. Wilmot Care Center Inc was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 32332 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 8/31/21 through 9/1/21. Wilmot Care Center Inc was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lan Van Beek — TITLE: Administrator — (X6) DATE: 9-23-21

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