

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Walworth County Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4861 Lincoln Avenue Selby, SD 57472	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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.</p> <p>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.</p> <p>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 resident's room, but she should have.</p> <p>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.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>10. Review of resident 12's EMR revealed she was readmitted to the facility on [DATE]. Her 4/17/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 (continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>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 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 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 (continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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 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.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 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 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.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>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 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. 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 inner buttocks. Barrier cream applied. Lotion applied to extremities. On 4/23/26, her skin observation (continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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].</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Walworth County Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4861 Lincoln Avenue Selby, SD 57472	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>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 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.</p>		