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

PRINTED: 06/27/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	N OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			С			
		435094	B. WING _				24/2024
NAME OF PROVIDER OR SUPPLIER  WAKONDA HERITAGE MANOR			STREET ADDRESS, CITY, STATE 515 OHIO STREET WAKONDA, SD 57073	, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 000	CFR Part 483, Subpa Term Care facilities w The area surveyed in care/treatment related	to a choking episode.	FO	00			
F 803 SS=D	compliance with the formula Menus Meet Resident CFR(s): 483.60(c)(1)-	the substitution list policy and the up add special meals/holiday meals to the substitution list policy and the up add special meals/holiday meals to the substitution and substitution list as well as our normal substitution policy.		n 6/27/24 and 6/28/ and the updated ne meals to the subst substitutions per ou	24 on ed to itution r current	07/03/2024	
	guidelines.; §483.60(c)(2) Be prep	ce with established national pared in advance;		Dietary manager created a new dine-in form shared with the registered dietician (RDN) a activity director (AD) in order to track any pladine-ins, special meals/holidays meals so the can be emailed to the RDN for approval pric special meals/holidays meals or dine-ins on the new dine-in form was created and district the contract of the form was created and district the contract of the form was created and district the contract of the form was created and district the contract of the form was created and district the contract of the form was created and district the contract of the form was created and district the contract of the co		of the nned form to the urring. outed on by CDM.	
		based on a facility's e religious, cultural and sident population, as well as		System monitoring: The C conduct audits on the sub-dine-in form being comple having the RDN's approva will be conducted weekly months with results being QAPI team by the CDM, F team will review results ar recommendations. After t RDN will resume per our content of the sub-distribution of the s	stitution form and it ted on a timely bas al of all substitutions x 4 weeks and mon reported to the mon RDN or designee. Cond make appropriate this time, monthly a	ne new is and s. Audits thly x 3 nthly QAPI	
	§483.60(c)(5) Be upd						
,	§483.60(c)(6) Be revidentian or other clinic professional for nutriti	ally qualified nutrition					
	construed to limit the personal dietary choice	in this paragraph should be resident's right to make ses. is not met as evidenced					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  Robin R. Stockland Administrator 07/03/2024							

Any deficiency statement ending with an asterisk (f) 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 than of correction is provided. For rursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If defidencies are cited, an approved plan of correction is requisite to continued program participation.

program participation.

JUL 0 3 2024

S. C.

Event ID: Q1C611

1110

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

		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION  G		C C		
		435094	B. WNG_			06/24/2024		
NAME OF PROVIDER OR SUPPLIER  WAKONDA HERITAGE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 803	by: Based on observation and policy review, the menu substitutions for reviewed and approve Findings include:  1. Observation on 6/2 resident 1 in the dining the was assisted into wheelchair by a staff this juice, water, and for him. *Dietary staff brough plate which consisted potato, and wax bear the meatballs were the used weighted go steady.  2. Interview on 6/24/11 in his room revealed the had an issue with and went to the hosp the had an issue with and went to the hosp the said he had issue was better now. *The meal he was seen and potatoes for a specific the was "ok" with his the was "ok" with his the was "ok" with his the was "ok" with resident with resident the meal on the meal on the meal specific the was "other meal on the meal specific the meal specific the meal specific the meal on the meal specific the m	en, interview, record review, e provider failed to ensure or special events were ed by a registered dietitian.  4/24 at 12:08 p.m. of any room revealed:  to the dining room in his member. If soy milk were at the table of meatballs, a baked ans.  ground.  cut into small pieces.  Illoves to keep his hands  24 at 1:35 p.m. with resident ed:  the choking a few days ago sital.  erved that day included steak pecial Father's Day meal.  es with swallowing but that  and up now and his other food eces.  Is new diet.  In ord review on 6/24/24 at 3:00 mager C regarding the to revealed:  enu for supper on 6/14/24 at 3:00 mager C regarding the to revealed:  enu for supper on 6/14/24 at 3:00 mager C regarding the to review on 6/24/24 at 3:00 mager C regarding the to review on 6/24/24 at 3:00 mager C regarding the to review on 6/14/24 at 3:00 mager C regarding the to review on	F8	03				

## 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  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435094	B. WING _			1	C <b>24/2024</b>	
	ROVIDER OR SUPPLIER  A HERITAGE MANOR			STREET ADDRESS, CITY, STATE, ZIP CO 515 OHIO STREET WAKONDA, SD 57073	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 803	steak and foil packets carrots, onions, and be a standard to before they were cool *She cut up the steak were served.  *Resident 1 was originegular meat and stafted -He came back from the aspeech evaluation.  -On 6/19/24 the spee eval and education to with ground meat.  -He was now on NDD with ground meat.  *The female residents listed on the menu.  *The June menu substandard the stepackets to the menu registered dietitian to *It was her expectation added those food item the dietitian to review  4. Interview on 6/24/2 of nursing (DON) Breat and emergency response revealed:  *All the nursing staff a included choking response included c	cial Father's Day meal of a that contained potatoes, butter for the male residents. He steaks in the morning ked. Is for residents before they mally on an NDD2 diet with forward with an order for the hospital with an order for the hospital with an order for the change his diet to NDD2  2 diet (moist, soft foods)  3 were served what was stitution log revealed staff eak and vegetable foil substitution log for the review and approve.  3 and approve.  4 at 3:30 p.m. with director egarding resident choking onse in the dining room  are CPR certified which conse.  I training to go over es that pertain to the ellity.  INDD2 diet with regular	F	803				

### 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  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		435094	B. WING			C 06/24/2024	
		455054	B. VIIIVO	07	TREET ADDRESS, CITY, STATE, ZIP CODE	06/	24/2024
NAME OF PI	ROVIDER OR SUPPLIER				IS OHIO STREET		
WAKOND	A HERITAGE MANOR				AKONDA, SD 57073		
	OLUMNIA DV OT	ATEMENT OF DEFICIENCIES	,				0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803	*The evaluation was a his diet was changed 5. Interview and recorp.m. with licensed praregarding resident 1's revealed:  *She worked the day *Resident 1 was in the but did not want to earnausea.  *He was taken back to some watery emesis *She gave him Zoframausea per his doctor *He continued to have the day but denied ar *She called an electroservice, and they recomergency room (ER *He was evaluated in the hospital for they restant from his throat Day meal the night be *They had removed to steak from his throat Day meal the night be *The speech evaluatin NDD2 with soft meats *He would be moved dining room to allow to observation for signs 6. Interview on 6/24/2 administrator A regardincident revealed:  *They provide special	completed on 6/19/24 and to NDD2 with ground meat.  Index review on 6/24/24 at 4/25 actical nurse (LPN)D is choking incident on 6/14/24 ashift on 6/15/24.  Index red in the state of the s	F	803			

# 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 A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		435094	B. WING_				24/2024
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 803	address choking issu *There was always a department in the din *She was not sure if of documented the spec substitution sheet for approve. *She agreed the dieta followed the policy fo  Review of the provid policy dated 2021 rev *"Menu substitutions discussion with the di services whenever posubstitutions may nee uncontrollable situation when a food item is to *3. All changes to the menu item substitution substitution) will be re *4. The registered die periodically evaluate	e trained in CPR and to es. member of the nursing ing room. dietary staff had ever cial meal menus on the the dietitian to review and ery staff should have r menu substitutions. er's menu substitutions er's menu substitutions ealed: will be made after frector of food and nutrition possible. Last minute ed to be made for ons (ie. inventory emergency emporarily unavailable) e menu (including the date, on, and reason for the ecorded. etitian (RDN) or designee will menu changes and if ote plan of action will be	F8	03			