STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435094	A. BUILDING B. WING	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakonda Heritage Manor	515 OHIO STREET , WAKONDA, South Dakota, 57073

(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/5/26 through 5/7/26. Wakonda Heritage Manor was found not in compliance with the following requirements: F604, F641, F695, and F921. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/5/26 through 5/7/26 . Areas surveyed included resident elopement and resident abuse and neglect. Wakonda Heritage Manor was found in compliance.	F0000		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of	F0604	F0604 Corrected to the individual: resident #6 was assessed by the IDT on 05/06/2026 to ensure interventions and care practices complied with current physician orders, resident rights, and facility policy regarding restraints and restrictive devices. Any identified concerns were corrected immediately. Identification of other residents potentially affected: An audit was conducted on all residents utilizing restrictive devices/interventions including, but not limited to, tilt-in-space wheelchairs, bed rails, positioning devices, manual recliners with feet elevated, and low beds to determine compliance with resident rights, physician orders, assessments, care plans, and documentation requirements related to restraint use. (Continue on next page)	05/29/2026

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 reverse for further 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
Robin R. Stockland	Administrator	05/22/2026

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F0604 SS = D	Continued from page 1 discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure there was documentation to support if one of one sampled resident (6) 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 method, or for a restraint elimination. Findings include: 1.Observation on 5/5/26 at 1:34 p.m. of resident 6 revealed she was sitting in the lounge area in a manual recliner with her feet elevated, watching a movie on the television. 2. Observation on 5/5/26 at 2:20 p.m. of resident 6 revealed she was sleeping in a manual recliner in the lounge area with her feet elevated and a Tab monitor (alarming device to alert staff of movement) was attached to her clothing. 3. Review of resident 6's electronic medical record (EMR) revealed she was admitted to the facility on 12/29/22. Her 3/2/26 Brief Interview for Mental Status (BIMS) assessment score was 2, which indicated her cognition was severely impaired. She had a physical restraint consent dated 3/8/26 for a Tabs alarm/pressure mat signed by her family member. She had a 4/8/26 physician's order, which indicated to ensure the resident had her Tabs alarm on everyday and night shift due to her dementia (a group of symptoms affecting memory, thinking, and social abilities). Her 5/6/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area of "I need help with all activities of daily living [ADLs]. I am frequently incontinent of my bladder. I am unsteady at times." The interventions included "may use a recliner without feet up," initiated on 11/5/24.	F0604	(F0604 continued from page 1) System corrections: Re-education was provided to licensed nursing staff regarding: definition of physical restraints per CMS guidance, resident rights related to restraints, appropriate assessment, documentation, care planning requirements, least restrictive interventions and monitoring and release requirements when applicable. Facility policy regarding restraints and restrictive devices was reviewed and updated to align with current CMS regulations and guidance. The IDT team will review all newly identified restrictive interventions prior to implementation to ensure compliance with regulatory requirements. A restraint/restrictive device audit tool was implemented for ongoing monitoring. System monitoring: DON or designee will complete weekly audits of residents with restrictive devices/ interventions for 8 weeks then monthly for 4 months thereafter to ensure: appropriate assessments were completed, physician orders were obtained, care plans were updated, documentation reflects medical symptoms and least restrictive interventions were used, and resident rights are maintained. Audit results will be reviewed by the DON or designee with the QAPI team at monthly QAPI meetings and any additional education or corrective action will be implemented as indicated.	

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F0604 SS = D	Continued from page 2 Her 7/6/25 lift chair safety assessment indicated, "I am not safe to use a lift chair on my own. I have a manual recliner in my room." She had a 3/9/26 physical restraint assessment that indicated there was continued imminent danger to the resident or others and that she had an unsteady gait, agitated behaviors, forget her ambulation device, had frequent falls, attempted to self-transfer, and climbs out of bed. The alternative methods that were attempted included the alarm devices on her bed, and chair. She had nursing progress notes that indicated she fell in the lounge area on 3/31/26 and 4/5/26. She had a behavior progress note dated 5/1/26, which indicated "Resident has been noted to be attempting to stand up out of [her] recliner, leaning forward in her recliner and trying to take her Tabs alarm off this shift. Resident has been repositioned in her recliner with her feet up to relax." 4. Interview on 5/5/26 at 2:49 p.m. with resident 6's family member revealed he visited the resident often, and had no concerns about her care. He was aware she had a tabs monitor, and that she was unable to put the foot of the recliner down herself since, her strength had decreased. He wanted her to be comfortable and pain free. 5. Observation and interview on 5/6/26 at 11:35 a.m. with activity director (AD) F revealed resident 6 was leaning forward in her wheelchair, sitting at the nurse's station waiting for lunch. She was removing her gripper socks; her Tabs monitor was attached to her shirt and wheelchair. AD F stated that resident 6 could be very active at times, and she does self-transfer out of her wheelchair. She did not think resident 6 could manually work the recliner lever when she was sitting in the lounge recliner. 6. Interview on 5/6/26 at 1:47 p.m. with certified nursing assistant (CNA) H revealed that resident 6 could not release the manual recliner herself. She was not supposed to have her feet in the upright position when sitting in the recliner in the lounge. Resident 6's care plan indicated that her feet were to always be down.	F0604		

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F0604 SS = D	Continued from page 3 7. Interview and EMR review on 5/7/26 at 8:48 a.m. with minimum data set (MDS) Coordinator/registered nurse (RN) D revealed she and director of nursing (DON) B updated the nursing part of the resident's care plans. MDS/RN D did not consider resident 6's feet being elevated in the recliner a restraint because she could put the chair down at times; the staff were elevating it for comfort. The staff were educated regarding following interventions on the resident's care plans, pocket care plans (a document that identifies a resident's care needs and interventions) and referencing the change of shift report (report by nursing when new shift comes on). MDS/RN D completed the quarterly and annual restraint assessments for the residents, and the direct care nurses completed the initial one. Resident 6 had a 3/9/26 restraint assessment completed, and a consent for the Tabs alarm was obtained at that time, there was no documentation on the physical restraint assessment form to support why it was not considered a restraint. 8. Interview on 5/7/26 at 9:10 a.m. with DON B revealed the staff refer to the pocket care plans for resident information. She was aware of the care plan intervention to not elevate resident 6's feet in the recliner. She agreed it appeared to be a restraint, but felt that the staff did not intend to restrain resident 6 in the recliner. DON B acknowledged that resident 6 was restrained during the surveyor's observations. 9. Review of the provider's revised 12/31/25 Physical Restraint policy revealed "Purpose: To standardize the Restraint Policy to provide guidelines for the appropriate use of physical and/or chemical restraints int the Avera LTC [long-term care] facility setting. This assures Avera restraint procedures are consistent, compliant, and provides reliable communication to all departments and Avera LTC facilities." "Policy Scope: This policy will apply to all individuals implementing physical and/or chemical restraints at Avera LTC Facilities. It is the responsibility of each Director of Nursing to assure the entities do not have policies that conflict with the content of this policy. Avera entities are required to adopt Avera LTC Governance Committee policy. Physical restraint: any manual or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom or movement or normal access to one's	F0604		

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F0604 SS = D	Continued from page 4 body. Physical restraints include but are not limited to leg or arm restraints, bolster mattresses, hand mitts, soft ties or vests, leg cushions and lap tray the resident cannot remove, and tucking a sheet around a resident so that resident cannot move. Freedom of movement: means any change in place or position for the body or any part of the body that the person is physically able to control. Removes easily: means the manual method, device, material, equipment can be removed intentionally by the resident in the same manner as it was applied by staff, considering the residents physical condition and ability to accomplish objective."	F0604		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F0641	F0641 Correction to individual: resident #1's MDS was reviewed and corrected on 05/18/2026 to accurately reflect the diagnosis documented in the medical record and addressed in the care plan. The interdisciplinary team reviewed the resident's clinical documentation on 5/18/2026 to ensure consistency between physician documentation, care planning, and MDS coding. The corrected MDS assessment was submitted on 5/18/2026 in accordance with the RAI guidelines. Identification of Other Residents Potentially Affected: audits are being conducted on current residents with diagnoses reflected in the care plans to ensure corresponding diagnoses were accurately coded on the MDS. Any discrepancies identified during the audit are being corrected promptly and resubmitted as appropriate. All residents' records will be reviewed and corrected if needed by 06/19/2026. System corrections: The facility implemented the following measures to prevent recurrence. Re-education was provided to the MDS Coordinator and interdisciplinary team on (5/19/26) regarding accurate coding requirements, including verification of diagnoses documented in physician records, active diagnoses, and care-planned conditions. The facility updated its MDS review process to include a secondary verification comparing: Physician documentation, active diagnosis list, care plans and MDS diagnosis coding sections. A pre-submission MDS accuracy checklist was implemented to ensure diagnoses addressed in care plans are reviewed for appropriate MDS coding. Education included review of current RAI Manual guidance regarding active diagnoses and interdisciplinary documentation requirements. (continued on next page)	06/19/2026

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F0641 SS = D	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure one of one sampled residents' (1) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment was accurately coded for the area of active diagnoses. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the facility on 9/15/25. On 1/5/26 a post -traumatic stress disorder (PTSD) diagnosis was added to her diagnoses. Her 3/24/26 quarterly MDS Assessment, section I (active diagnoses) under Psychiatric/Mood Disorder did not have the diagnosis I6100 Post Traumatic Stress Disorder marked. 2. Interview and EMR review on 5/7/26 at 8:42 a.m. with MDS Coordinator/ registered nurse (RN) D revealed she acknowledged resident 1 had a diagnosis of PTSD when her 3/24/26 quarterly MDS assessment was completed. MDS/RN D agreed that resident 1's section I under Psychiatric/Mood Disorder should be marked for PTSD and considered PTSD to be an active diagnosis for resident 1. She used user-defined assessments (UDA's) completed by the nurse, physician's orders, the resident diagnoses, progress notes, and staff interviews when completing the MDS assessments for residents. She referenced the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 to complete the residents' MDS assessments. 3. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed "Section I, Page I1 and I2, Steps for Assessment: 1. Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes,	F0641	(F0641 continued from page 5) System monitoring: The MDS Coordinator or designee will complete audits of newly completed MDS assessments weekly for 4 weeks, then monthly for 5 months to verify diagnoses identified in care plans are accurately coded on the MDS. All audit results will be reviewed by the MDS coordinator or designee to the QAPI team at monthly QAPI meetings x 6 months. Additional education or corrective action will be implemented if concerns or patterns are identified.	

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F0641 SS = D	Continued from page 6 and other resources as available."	F0641		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure infection control practices were followed regarding one of two sampled resident (34) who used a nebulizer (a device that converts liquid medication into an inhalable mist) machine that was not cleaned after each use by the nursing staff. Findings include: 1.Observation on 5/5/26 at 9:38 a.m. in resident 34's room revealed she had a handheld nebulizer tube connected to a nebulizer machine that was placed in the holder on the machine. The medication chamber had a clear liquid at the bottom of the chamber. 2. Observation on 5/5/26 at 1:22 p.m. in resident 34's room revealed the nebulizer tube remained in the same position as the above observation with clear liquid in the medication chamber. 3. Observation and interview on 5/5/26 at 4:13 p.m. with resident 34 revealed she was unsure if registered nurse (RN) C had rinsed out her nebulizer tube after she used it this morning. 4. Observation on 5/6/26 at 8:10 a.m. in resident 34's room revealed the handheld nebulizer tube was lying on her bedside table with a small amount of clear liquid in the medication chamber. 5. Observation on 5/6/26 at 4:00 p.m. in resident 34's room revealed the handheld nebulizer tube was in the same position as it was at 8:10 a.m. that morning with a clear solution in the medication chamber.	F0695	F0695 Corrected to individuals: nebulizer equipment identified as improperly cleaned for resident #34 was immediately replaced and cleaned per facility infection prevention policy. All residents currently receiving nebulizer treatments were immediately assessed to ensure nebulizer cups and associated equipment were cleaned appropriately following administration. Residents with scheduled nebulizer treatments were assessed on 05/07/20026 and residents with PRN administration on 05/13/2026. System corrections: the facility policy regarding nebulizer treatment administration and post-treatment equipment cleaning was reviewed and updated to specifically include cleaning of the nebulizer cup immediately following each administration. The task of cleaning the nebulizer cup following treatment administration was added to the Treatment Administration Record (TAR) for all residents utilizing nebulizer treatments to ensure staff accountability and documentation compliance. Education regarding the cited deficiency, revised policy, proper nebulizer cleaning procedures, infection prevention standards, and expectations for compliance will be provided to licensed nursing staff by 5/22/26. Additional nebulizer education will be completed monthly for six (6) months for all licensed nursing staff to reinforce proper procedures and infection control practices. System monitoring: DON, Infection Preventionist (IP), or designee will conduct nebulizer cleaning audits as follows: Weekly for 2 months and then monthly audits for 4 months. Audits will include observation of nebulizer treatment administration, verification of proper cleaning following treatment, and review of TAR documentation compliance. Any identified concerns will be addressed immediately through re-education and corrective action as appropriate. Results of the audits will be reviewed by DON, IP or designee with the QAPI team at monthly QAPI meetings. Additional interventions will be implemented as indicated based on audit findings and trends.	05/29/2026

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F0695 SS = D	Continued from page 7 6. Review of resident 34's electronic medical record (EMR) revealed she had a 10/10/25 physician's order for Budesonide(a inhalant that reduces airway inflammation) suspension 0.5 milligrams (mg)/2 milliliters (mL) to be administered via nebulizer by mouth two times daily for Chronic Obstructive Pulmonary Disease (COPD) (a group pf lung diseases that block airflow and make it difficult to breathe). She had a 10/10/25 physician's order for Formoterol (a long-acting inhalant that reduces wheezing and shortness of breath) nebulizer 20 microgram (mcg)/2mL to be administered orally two times a day related to COPD. 7. Interview on 5/6/26 at 4:05 p.m. with licensed practical nurse (LPN) E revealed she administered nebulizer treatments that morning to resident 34. Resident 34 received Budesonide and Formoterol using her nebulizer, which were administered separately. LPN E would take apart the medication chamber and pieces, rinse them out, and place them on a barrier to air dry after the resident finished her nebulizer treatments. LPN E did not clean the nebulizer attachments that day (5/6/26). 8. Interview on 5/7/26 at 9:04 a.m. with director of nursing (DON) B revealed she expected the staff to follow the policy for rinsing out the nebulizer medication chamber and pieces after each administration of medication and to verify the medication was administered. The nebulizer medication chambers, and tubing were changed weekly by the nurses. 9. Review of the provider's February 2026 Oxygen Administration and Nebulizer Treatment policy and procedures revealed "To ensure safe administration, monitoring, and documentation of oxygen therapy and nebulizer treatments while promoting resident safety, infection control, and compliance with regulatory standards. Nebulizer Equipment: Nebulizer mask or pipe must be cleaned after each use. Disinfected according to manufacturer guidelines and facility infection control procedures-equipment disinfected weekly and clean filters. Change nebulizer mask and pipe weekly (dated and nurses initials). Allowed to air-dry completely before reuse. Single-resident equipment shall not be shared between residents."	F0695		
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions	F0921	F0921 See next page for narrative.	05/29/2026

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F0921 SS = D	Continued from page 8 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure chemicals were stored safely away from the residents in one of two bathing rooms. Findings include: 1. Observation on 5/5/26 at 2:51 p.m. of the bathing room revealed the room was unattended and the door was unlocked. The storage cabinet that contained skin care products and chemicals was also unlocked. Contents of the storage cabinet included a spray bottle of Ecolab rapid Multi Surface Disinfectant Cleaner, an aerosol can of Arrid extra dry antiperspirant, a can of UtlraSure deodorant body spray, a bottle of Jurgens ultra healing lotion, a bottle of Olay body wash, a bottle of Eucerin itch relief intensive calming lotion, a bottle of Head and Shoulders shampoo, a bottle of Dove ultra care shampoo, two tubes of Remedy clinical skin cream, a stick of Brut deodorant, a bottle of Selsun blue anti-dandruff shampoo with 1% (percent) Selenium Sulfide, a stick of Degree deodorant, a tube of McKesson skin protection ointment with vitamin A and D, and a stick of Axe antiperspirant. A bottle of Gentell baby shampoo was on top of the storage cabinet. 2. Observation on 5/6/26 at 11:03 a.m. revealed the bathing room door was unlocked and the storage cabinet door was also unlocked, which allowed residents to have access to all the items inside the cabinet. There were several residents who went by the bathing room on their way to the dining room for lunch. 3. Interview on 5/6/26 at 12:06 p.m. with certified nursing assistant (CNA) I regarding the bathing room revealed the door should be locked. They did have one resident who was independent with showers, and she took a shower yesterday (5/5/26). The door must not have gotten locked after she was done. CNA I knew the bathing room door was to be locked since there were chemicals stored there that the residents should not have access to. 4. Interview on 5/7/26 at 10:00 a.m. with administrator A regarding chemical storage in the bathing rooms revealed that she knew there were some cleaning chemicals and resident bathing products stored in the bathing rooms. She expected the bathing rooms to be locked when they were not in use. 5. Review of the provider's CMS 802 matrix for providers (a document used by long-term care	F0921	(F0921 continued from page 8) System correction: upon identification of the deficiency on 05/08/2026, the shower room door was immediately locked. The chemicals inside the cabinet in the shower room were removed until a lock could be installed on the cabinet. The shower room door lock was replaced with the same type of lock utilized on the bath house door on 05/13/2026 with matching key to ensure consistent security and staff accessibility. All chemicals in shower room were reviewed to ensure proper labeling, storage, and compliance with facility safety and infection control policies. Padlock placed on cabinet on 05/13/2026. Systemic changes implemented: To prevent recurrence, the facility implemented the following corrective measures: Reviewed and reinforced policies related to hazardous chemical storage, environmental safety and securing resident care areas. Education provided to nursing staff, housekeeping & maintenance staff and department managers. Education included; proper storage and security of hazardous chemicals, requirement to keep shower rooms secured when unattended and chemical storage cabinets locked. Resident safety and environmental hazard prevention. Safety rounds were completed to inspect all shower rooms, housekeeping closets, utility rooms and chemical storage areas to ensure all hazardous substances are properly secured and all required locks are functioning appropriately. Any identified unsecured areas or were corrected immediately. Staff education will also be completed at all staff meeting on 5/28/2026. System monitoring: The Admin, DON, Environmental Supervisor (ES), or designee will conduct environmental safety audits as follows: Weekly x 4 weeks, then monthly x 5 months. Audits will include; verification that shower rooms are secured when unattended and chemical cabinets remain locked. Verification that hazardous chemicals are appropriately stored and labeled. Verification that door locks are functioning properly and observation of staff compliance with facility safety practices. Any concerns identified during audits will be corrected immediately and addressed through additional staff education and/or corrective action as indicated. Results of environmental safety audits will be reviewed by Admin, DON, ES or designee with the QAPI team during monthly QAPI meetings x 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakonda Heritage Manor	**515 OHIO STREET , WAKONDA, South Dakota, 57073**

(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
F0921 SS = D	Continued from page 9 facilities to list all residents and note specific care categories for Medicare/Medicaid surveys) revealed 21 residents were marked for having Alzheimer's/Dementia (a progressive neurodegenerative disorder that destroys memory, thinking skills, and the ability to carry out simple tasks). 6. Review of the provider's revised November 2025 Chemical Product Labeling and Storage policy revealed, "1. All chemicals must be kept inaccessible to residents and visitors when not in use."	F0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakonda Heritage Manor	515 OHIO STREET , WAKONDA, South Dakota, 57073

(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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 5/6/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Wakonda Heritage Manor was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0712 SS = D Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills per shift). Findings include: 1. Record review on 5/6/26 at 12:15 p.m. revealed there was no documentation of third shift fire drills for quarter four (October, November, December) of 2025. Further record review at that same time revealed that same condition existed for the first shift of quarter one (January, February, March) of 2025.	K0712	K0712 System correction: Maintenance director reviewed monthly fire drill logs and will develop a new format for his log book to stay on track with each shift having a drill during each quarter of the year. We are on track for the 1st and 2nd quarter of 2026. System monitoring: Maintenance director, Admin and/or designee will review fire drill log books prior to the end of each quarter to assure all 3 shifts have been covered. Audits will be conducted by maintenance director, admin and/or designee monthly x 6 months and results will be reported to the QAPI team at the monthly QAPI meetings x 6 months.	05/21/2026

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 reverse for further 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
Robin R. Stockland	Administrator	05/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakonda Heritage Manor	**515 OHIO STREET , WAKONDA, South Dakota, 57073**

(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
K0712 SS = D Bldg. 01	Continued from page 1 Interview with the maintenance director at the time of the record review confirmed those findings. He stated he was unaware the minimum number of fire drills for each shift per the required frequency had not been met for each shift in 2025. The deficiency had the potential to affect 100% of the occupants of the building.	K0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakonda Heritage Manor	**515 OHIO STREET , WAKONDA, South Dakota, 57073**

(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
E0000	Initial Comments 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 on 5/6/26. Wakonda Heritage Manor was found in compliance.	E0000		

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 reverse for further 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
Robin R. Stockland	Administrator	05/21/2026

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
	10701	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKONDA HERITAGE MANOR	515 OHIO STREET WAKONDA, SD 57073

(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 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/5/26 through 5/7/26. Wakonda Heritage Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland

TITLE: Administrator

(X6) DATE: 05/21/2026