STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435094	A. BUILDING _____ B. WING _____	C 02/13/2025

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/11/25 through 2/13/25. Wakonda Heritage Manor was found not in compliance with the following requirement: F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/11/25 through 2/13/25. Areas surveyed included resident safety related to a resident who had an injury from a lift chair and a resident who had choked on their meal. Wakonda Heritage Manor was found not in compliance with the following requirement: F689.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, observation, interview, and policy review the provider failed to ensure two of two sampled residents (3 and 21) who were assessed and determined unable to safely use electronic lift chairs independently did not have access to the lift chair control or the chairs' power cords were	F 689	F689 Corrected to individuals: Since resident #3 had been deemed unsafe to use a lift chair and the power cord had already been removed, on 2/14/25 the chair was removed from the room to ensure the safety of res. #3. On 3/5/25 a non-operational lift chair was put into res. #3's room. The rolling chair in resident #21's room was removed on 2/13/25 and stored until family picked it up on 3/3/25. The electrical wiring was disabled on the lift chair in res. #21's room on 2/14/25 by the maintenance director. Directed In-Service: Education was provided by DON & Administrator on 3/5/25 to RN/LPN staff. Education will also be presented at an all-staff meeting on 3/10/25 by the MDS coordinator and Admin to all other licensed and unlicensed staff. Training includes; - review of 2567 from 2/11/25 - 2/13/25 survey with description of Federal tags received. - education & description of the meaning of the scope & severity of F689 SS=G & F812 SS=F. -training provided to all licensed & unlicensed staff about their roles and responsibilities when caring for & supervising residents' needs and safety. (continued on next page)	03/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland | TITLE: Administrator | (X6) DATE: 03/13/2025

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 689	Continued From page 1 unplugged or removed as directed in their assessments. Findings include: 1. Review of the provider's 11/22/24 SD DOH FRI regarding resident 3 revealed: *On 11/22/24 at 7:45 p.m. resident 3 had fallen out of his lift chair. -The resident was found by registered nurse (RN) I in his room, lying face down on the floor with his head next to his bed -The resident denied having pain. -He was rolled onto his back with staff assistance. -His vitals were as follows: Blood pressure (BP) 122/79, pulse rate (P) 54, respiratory rate (R) 16 breaths per minute, and oxygen saturation (SpO2) (oxygen level in the blood) of 95%. -A hematoma (swollen, bruised area) was noted on the resident's forehead and a small laceration on his nose. -The resident was alert to self only and verbal with confusion. He could not provide information as to why he was found lying on the floor. -His call light remained clipped on to the resident's chest area of his shirt. -The lift chair was found to be in the most upright position. -His catheter bag remained attached to the pocket on the lower right side of the lift chair. -A call was placed to 911 by RN I. -At 8:33 p.m. the resident was evaluated by emergency medical services (EMS). -His blood glucose was tested and found to be 150, BP 120/85, P 61, R 16, and SpO2 98%. -The resident was transferred to the local hospital by EMS at 8:50 p.m. -At 9:03 p.m. his family was notified of the incident. -His primary care provider (PCP) was notified of	F 689	F 689 Directed In-Service continued -Educated nursing staff on updated "Lift Chair Safety Assessment" policy & procedure and their role in ensuring the other staff follow through with what is care planned or each resident. -Educated charge nurses on the tasks that have been included in the TAR for them to complete when checking each resident who has been deemed unsafe to operate a lift chair to ensure their chair remains non-operational or no lift chair at all in their rooms. Corrected to all others: All lift chairs in the day lounge/TV lounge area of the facility were disabled by the maintenance director on 2/28/25. New lift chair assessments were completed by DON for all current residents by 3/5/25. All residents that were deemed unsafe to operate a lift chair have had the power source disabled by the maintenance director or a regular recliner has been moved into their room. All care plans were updated on 3/5/25 to reflect the new lift chair assessment and they were individualized to each resident on the reason they were unsafe to operate a lift chair or that they were safe and do have a lift chair in their room. Any current residents who have been deemed safe to operate a lift chair will continue to have at a minimum quarterly assessments completed, also if their is a significant change or readmission from a hospital stay to ensure the current residents are still safe to operate their lift chairs. System correction: Medical Director was notified of surveyors in the facility on 2/11/25 and again notified on 2/15/25 about the deficient areas that were noted during the survey exit meeting. The "Lift Chair Safety Assessment" policy and procedure was updated on 2/28/25 and includes terminology that effective 3/1/25 lift chairs will no longer be allowed for new admissions to the facility. This will be included in our admission packet and education will be provided to families and residents during the admisssion process. The Medical Director is in agreement with the updated policy and procedure. The DON also updated all Pocket Care Plans (CNAs carry these) on 3/6/25 to reflect lift chair status. (Continue on next page)	

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F 689	Continued From page 2 the incident. 2. Review of resident 3's electronic medical record (EMR) revealed: *A Lift Chair Assessment had been completed on 4/22/24, 9/6/24, 10/16/24, and 11/29/24. -Each individual assessment had indicated that the resident did not meet the criteria to safely operate a lift chair independently. *A physical restraint assessment was completed on 4/4/23 and had indicated staff were to hook the control for the lift chair on the backside of the chair and to reassess quarterly. *He had a history of raising the lift chair in an upright position and falling when he was sitting in it and had access to the control. *His baseline care plan indicated he had Depression, Paranoid Schizophrenia (one's mind doesn't agree with reality such as hallucinations and delusions), Epilepsy (brain disorder that causes seizures), Insomnia, Aphasia (language disorder that affects one's ability to communicate), and Cerebral Infarction (stroke). -He had tremors that were not related to his medications. -He had balance problems and a history of falls. *On 11/12/24 he had a Brief Interview for Mental Status (BIMS) assessment with a score of 6, which indicated he was severely cognitively impaired. *His care plan had been updated on 12/3/24 to include he did not meet the criteria to safely operate his lift chair independently and would utilize his call light and request assistance to get to and from the chair. 3. Observation on 2/11/25 at 2:30 p.m. of resident 3's room revealed: *The lift chair was plugged into an outlet behind	F 689	F689 Continued Type text here Monitoring of System: Charge nurses will monitor all chairs in residents' rooms who have been deemed unsafe, to ensure the chair in their room is non-operational if it is a power lift chair or that it is not a power chair, on a daily basis. This task/ audit has been created in the TAR (treatment administration record) of the residents' EMR. The charge nurse will also monitor residents' who are deemed safe to operate a power lift chair but have chosen to use a manual chair or a non-operational lift chair, on a daily basis. The task/ audit on the TAR will verify if the chair in their room is a manual chair or non-operational lift chair. The completion of these tasks on the TAR will be audited by the DON or designee monthly x 6 months to ensure compliance. All results will be reported to the QAPI team at monthly QAPI meetings by the DON or designee. Maintenance director or designee will audit all lift chairs to identify any mechanical issues to ensure safety of all lift chairs that are in service in the facility. These audits will be completed weekly x 1 month and then monthly x 6 months with all results reported to the QAPI team at the monthly QAPI meetings by the maintenance director or designee.	

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F 689	Continued From page 3 the chair with the control inside its side pocket. -The chair raised and lowered with the use of the control. 4. Observation and interview on 2/11/25 at 10:45 a.m. with resident 3 who was seated in his wheelchair with call light attached to his blanket that was draped over his lap was attempted but he was unable to provide adequate information related to the above fall with injury. *There were no observations at any time, of resident 3 sitting in the lift chair. 5. Interview on 2/11/25 at 2:37 p.m. with certified nursing assistant (CNA) G regarding resident 3 revealed: *He rarely used the lift chair in his room, and when he did, he felt they made sure it was unplugged. -The lift chair was used to raise his legs to decrease the edema in his lower legs. 6. Observation on 02/12/25 at 10:13 a.m. revealed: *Power cord remained attached to the lift chair in resident 3's room. 7. Random observations of resident 3 during the survey revealed he had not been in the lift chair and the control was in the lift's side pocket. 8. Interview on 2/12/25 at 3:15 p.m. with RN C revealed: -The lift chair belonged to resident 3 and was to remain in his room, unplugged and without availability for his use of the remote. -He was not sure why the lift chair remained in resident 3's room, other than it belongs to the resident.	F 689		

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F 689	Continued From page 4 -Resident 3 no longer sat in his lift chair due to his history of falls with the use of the chair. 9. Observation on 02/13/25 at 9:10 a.m. of resident 3's room revealed the lift chair's electric power cord had been removed. 10. RN I was not available for interview at the time of the survey. 11. Observation and interview on 2/11/25 at 12:44 p.m. with resident 21 in her room revealed: *Her speech was unclear, and she was not able to answer any direct questions. *She walked with an unsteady gait. *There was an electric lift chair and a wheeled, swivel desk chair with a throw blanket draped over it that hung near its wheels. 12. Observation on 2/13/25 at 8:50 a.m. of resident 21 in her room revealed: *She sat herself in the electric lift chair. *The control for that chair was on the right-side armrest. *That control lifted and lowered that chair when the button was pressed. *She then tucked that control between the armrest and the back of the chair. 13. Observation and interview on 2/13/25 at 10:04 a.m. with CNA H in resident 21's room revealed: *Resident 21 often knew what she wanted but had a difficult time communicating with words. *CNA H stated the wheeled swivel desk chair looked like a fall hazard, but resident 21 only sat in her electric lift chair. She had not seen resident 21 sit in the desk chair. *The desk chair was where resident 21 put her dirty clothes at night.	F 689		

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F 689	Continued From page 5 14. Review of resident 21's EMR revealed: *She was admitted to the facility on 12/29/22. *Her diagnoses included Alzheimer's disease with late onset and anxiety disorder. *Her BIMS assessment score was 00, which indicated she was severely cognitively impaired. *A 1/3/25 lift chair assessment determined "Resident is unsafe. Resident does not meet [the] criteria to operate lift chair independently." *Her care plan indicated: -"I will benefit from simple, repetitive, one-step instructions during activities." -"Encourage resident to sit in her recliner w/her [with her] feet up." -"Per lift chair assessment, I am not safe to use the controls on my own." 15. Interview on 2/13/25 at 1:29 p.m. with director of nursing (DON) B regarding electric lift chairs revealed: *All residents were assessed for the safe use of electric lift chairs on admission, quarterly, and with any significant change. *The care plan should have indicated if a resident was unsafe to use an electric lift chair. *Residents were allowed to have an electric lift chair in their room as long as it had been unplugged. *Staff removed the electric lift chair's power cord from some residents' chairs and some residents were required to call for assistance with using the lift chair. -Staff would plug the electric lift chair in at that time and then unplug it after it had been positioned. *Power cords would be removed from the chair and from the resident's room if a resident could not comprehend the safe use of the lift chair. *She expected resident 3's electric lift chair to	F 689		

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F 689	Continued From page 6	F 689		

have been unplugged because the assessment had determined he was unsafe to use that chair independently.
*She expected resident 21's electric lift chair to have been unplugged because the assessment had determined she was unsafe to use that chair independently.
*Staff knew which residents required assistance with their lift chairs and which lift chairs were to remain unplugged because it was on the resident's EMR and paper care plan.
*She was unaware resident 21 had a wheeled, swivel desk chair with a throw blanket draped over it in her room.
*She thought resident 21's family may have brought that desk chair in and stated, "We certainly would not have given her a chair with wheels."
-She would discuss removing the desk chair with resident 21's family.

16. Review of the provider's "Resident Lists of Cares" paper care plan revealed:
*Resident 3 had a "Recliner in [the] room, resident not safe to operate independently. Must remain unplugged."
*Resident 21 was "Safe to use lift chair independently."

17. Review of the provider's October 2024 LTC (Long Term Care) Lift Chair Safety Assessment policy revealed:
*"Before a lift chair is used by a resident, a member of the interdisciplinary team will complete a lift chair safety assessment."
*"If the assessment deems the resident can safely operate [the] lift chair, [the] lift chair will remain in Residents [resident's] room with full power function of lift chair. If the resident is

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F 689	Continued From page 7 unable to safely operate the lift chair, the power to the chair will be disabled and the chair will remain in the sitting and sedentary position." 18. Review of the provider's 10/1/24 Lift Chair Assessment policy revealed: *"Lift chair assessments will be completed in Point Click Care on each resident upon admission to the facility, quarterly and with any significant change." *"The purpose of the assessment is to determine whether resident can safely operate the chair independently. Results will be care planned." *"Risks associated with lift chairs include but are not limited to the following:" -"Falling out of the chair which could cause serious injury and potential death." -"Cognitive decline may lead to poor judgement related to when and when not to engage the chair." -"Individuals who use mobility devices may have an increased risk for falls." -"Risk of injury may be higher for those who present with the multiple factors and spend prolonged periods of time using the device unsupervised."	F 689		
F 812 SS=F	Food Procurement, Store/Prepare/Serve-Sanitary 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.	F 812	F812 System correction: RD was notified by CDM and Administrator on 2/27/25 about the F 812 deficiency and Directed In-Service component. RD was asked to come to the facility prior to 3/13/25 to train all dietary staff in proper food safety and hand/glove use. RD was unable to commit to this as RD was going to be gone, but she sent a Food Safety Inservice titled "Hand Hygiene & Glove Use" by Dakota Dietitians for us to use to train all dietary staff. The CDM from our sister facility will train staff on 3/7/25 on this inservice. (continue on next page)	Addendum: 03/13/2025

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F 812	Continued From page 8 (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: Based on observation, interview, and policy review, the provider failed to ensure appropriate hand hygiene and glove use was performed to prevent contamination of resident foods by two of two dietary staff (dietary manager J and medical secretary K) during one of one observed meal service in the kitchen and dining room. Findings include: 1. Observation on 2/11/25 at 11:31 a.m. in the main dining room during the noon meal service revealed: *At 11:31 a.m. dietary manager (DM) J began to prepare the resident meal plates. *DM J wore gloves while she prepared to plate the resident's food. *While wearing those same gloves, she: -Touched the surface of trays that were being reused to deliver food to the resident's tables. -Repeatedly touched the individual resident's diet cards. -Touched her cap. -Touched plates and serving utensils. -Picked up ready to eat dinner rolls and placed them on plates. -Continued to dish up food and pick up dinner rolls until the meal service was finished, with	F 812	F 812 continued: CDM J has already reviewed and trained all dietary staff with a Food Safety In-Service from the Association of Nutrition & Food-service Professionals series titled "Personal Hygiene & Handwashing". This training was completed on 2/28/25 and all dietary staff were required to take a post test after the training session. Training for all dietary staff also included education about their role and responsibilities for meal prep and/or service and dining assistance. Directed In-Service: Education will be provided at All-staff mtg by Administrator, MDS coordinator & CDM on 03/10/25. Training includes: -Review of 2567 from 2/11/25 - 2/13/25 survey with description of Federal tags. -Education & description of the meaning of the scope & severity of F689 SS=G and F812 SS=F. -Training for all staff that, if they are ever involved in any type of meal prep and/or meal service and dining assistance that they understand their role and responsibilities as it relates to hand hygiene and proper glove use. CDM & Administrator have reviewed the policy and procedures for appropriate hand hygiene & glove use with meal preparation and meal service. Policy & procedures do not need to be revised, they just need to be followed. As of 2/13/25, dietary staff are now using a different/clean tray to deliver each resident's meal to their table. All dietary staff were educated on this change immediately via 1:1 communication from CDM and via communication book. (continued on next page)	

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F 812	Continued From page 9 those same gloved hands. *Medical secretary K delivered meals to the residents. She reused the same two trays to carry the meal items to the tables. -She asked DM J if she needed to wash her hands between meal deliveries and was told she did not. -She set the trays on the tables while serving the residents' meals. -She touched residents on their shoulders while serving the meals. -She did not wash her hands during the meal service. 2. Interview on 2/12/25 at 9:30 a.m. with DM J revealed: *She had worked in the dietary department for more than six years. *She provided the new employee and annual training for the dietary staff. *She did not think she needed to change gloves to serve the rolls. *She had not considered using tongs to serve them. *She thought she could change her gloves three times before she needed to wash her hands. *She did not know they should have used clean trays to deliver residents' meals. *That was the first time medical secretary K had helped with a meal service in the dining room. *She had told medical secretary K that she did not need to wash her hands between delivering resident meals. 3. Interview on 2/12/25 at 3:30 p.m. with director of nursing (DON) B who was the acting infection preventionist revealed: *She expected that kitchen staff would follow the hand hygiene and glove changing practices as	F 812	F 812 continued: Monitoring system: Infection Preventionist, CDM or designee will conduct audits on appropriate hand hygiene and glove use in the kitchen and in the dining room during meal prep and service. Audits will be completed weekly x 3 months, then monthly x 3 months. All audits will be reported to the QAPI team at the monthly QAPI meetings by the Infection Preventionist, CDM or designee.	

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F 812	Continued From page 10 stated in their hand hygiene policy. *She did not know why DM J thought she could change her gloves three times without washing her hands between each glove change. 4. Review of DM J's undated food safety staff in-service training on Personal Hygiene and Handwashing from the Association of Nutrition & Food Service professionals revealed to "always wash your hands:" -"Before putting on clean, single-use gloves for working with food and between glove changes." -"If you touch anything that may contaminate your hands, wash them." 5. Review of DM J's in-service training material from Horizon US Foodservice dated April 2006 on Proper Handwashing Technique revealed: -"If a food handler does not wash their hands before putting on gloves, the outside of the glove becomes contaminated." -"The food handler may contaminate the gloves by touching face, hair, equipment, etc." -"Gloves should be changed before handling ready-to-eat foods." 6. Review of DM J's undated in-service training material titled Glove Use and Bare-Hand Contact revealed: -"Disposable gloves are not a substitute for handwashing, and hands need to be clean before putting gloves on them." -"Anything that can contaminate your hands will contaminate gloves as well." -"Change gloves after touching your hair, face, or other non-disinfected surfaces." 7. Review of the provider's 11/14/2024 long term care (LTC) Hand Hygiene policy revealed:	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435094	A. BUILDING _____ B. WING _____	C 02/13/2025

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

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F 812	Continued From page 11 *"HH (hand hygiene) either with soap and water or with alcohol-based hand rub (ABHR):" -"After removing gloves." *"ABHR may be used instead of soap and water except when in a food preparation setting."	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435094	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2025**

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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 2/11/25 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 deficiency identified at K131 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served.	K 131	K 131 System correction: Maintenance director adjusted the latch on the fire door listed as the separation wall between the nursing home and the assisted living on 02/12/2025. This door now closes and latches correctly in order to provide fire separation between the nursing home and assisted living. System monitoring: Maintenance director or designee will conduct audits on all fire rated doors 1 time per week for 4 weeks, then monthly for 6 months with results from the audits to be reported at the monthly QAPI meeting by the maintenance director or designee. If any problem is noted during the audits it will be fixed immediately.	02/12/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin R. Stockland	Administrator	02/27/2025

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
	435094	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2025**

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

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K 131	Continued From page 1 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the fire-resistive design of one randomly observed building separation wall (between the nursing home and the service wing). Findings include: 1. Observation on 2/11/25 at 11:02 a.m. revealed a ninety-minute fire-rated door in the separation wall between the nursing home and the service wing. Testing of that door at the same time revealed it did not close and latch on three of three attempts. Interview with the maintenance assistant at the time of the observation and testing confirmed those findings. He stated he was unaware it was not properly latching as it had worked when he tested doors the previous month. The deficiency could affect 100% of the occupants of the smoke compartment.	K 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435094	A. BUILDING _____ B. WING _____	02/11/2025

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

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E 000	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 2/11/25. Wakonda Heritage Manor was found in compliance.	E 000		

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

TITLE: Administrator

(X6) DATE: 02/27/2025

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.

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 _____	02/13/2025

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

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S 000	Compliance/Noncompliance Statement 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 2/11/25 through 2/13/25. Wakonda Heritage Manor was found in compliance.	S 000		
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 2/11/25 through 2/13/25. 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: 02/27/2025