| 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 ______ | 10/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WAKONDA HERITAGE MANOR | 515 OHIO STREET<br>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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/17/23 through 10/19/23. Wakonda Heritage Manor was found not in compliance with the following requirement: F880. | F 000 | | |
| F 880<br>SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or | F 880 | Directed Plan of Correction<br>Wakonda Heritage Manor<br>F880<br><br>Corrective Action:<br>1. For the identification of<br>*Lack of appropriate hand hygiene and glove use during provision of personal cares<br>*Lack of appropriate maintenance and disinfection of EZ stand lift when shared between multiple residents.<br><br>The administrator, DON, infection control (IC) nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All staff who are responsible fo the above cares and services will be educated/ re-educated by 11/10/2023 by DON, IC nurse and/or designee for all identified staff including agency staff.<br><br>2. Identification of Others:<br>All residents and staff have the potential impact to be affected if lack of appropriate processes are in place and followed to eliminate the identified infection control issues. Policy education/re-education about roles and responsibilities for the above identified care and services tasks will be provided by 11/10/23 by DON, IC nurse and/or designee to all care staff including agency staff.<br><br>(F880 continued on next page) | 11/10/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland — TITLE: Administrator — (X6) DATE: 11/03/2023

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 ______<br>B. WING ______ | 10/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WAKONDA HERITAGE MANOR | 515 OHIO STREET<br>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 |
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| F 880 | Continued From page 1<br>infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and policy review the provider failed to ensure infection | F 880 | F880 continued<br><br>System Changes:<br>3. Root cause analysis conducted answered the 5 Whys:<br>Problem statement: CNAs E and F did not follow proper hand hygience and glove use during provision of personal cares.<br>Why? Staff did not sanitize hands upon entering the resident's room.<br>Why? Inadvertent human error: not enough training to ensure staff has habitualized the procedure.<br>Why? Staff did not perform proper dirty to clean practices.<br>Why? Staff didn't realize they were going from a dirty task to a clean task.<br>Why? Poor adherence to prior hand hygiene/ glove use training/education, demonstrating a need for re-education.<br><br>Problem statement: CNAs E and F did not properly sanitize the EZ stand lift between multiple residents.<br>Why? Poor communication.<br>Why? CNA E forgot to communicate to CNA F that the lift had not been sanitized before putting it in the hallway.<br>Why? Inadvertent human error: staff became distracted with performing resident cares and simply forgot.<br><br>Administrator, DON, medical director and any others identified as necessary will ensure all facility staff, including agency staff, responsible for the assigned tasks have received education/ training with demonstrated competency and documentation.<br><br>Administrator, DON and IC nurse contacted the South Dakota Quality Improvement Organization on 11/1/2023 and discussed the directed plan of correction for our recent SD DOH survey and the steps that we have taken and plan to take to assure our staff and our agency staff are educated in proper hand hygiene, glove use and equipment sanitization between residents. We discussed our audits and were also provided with infection control resources.<br>(F880 continued on next page) | |

| 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 _____ | 10/19/2023 |

| 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 |
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| F 880 | Continued From page 2<br>control policies were adhered to with the following:<br><br>*Appropriate hand hygiene and glove use by two of two certified nursing assistants (CNAs) E and F during the provision of personal care for one of one sampled resident (24).<br>*Appropriate sanitization of an EZ stand mechanical lift by CNAs E and F between care for two of two sampled residents ( 24 and 85).<br>Findings include:<br><br>Observation on 10/18/23 at 8:21 a.m. with CNA E and F assisting resident 24 revealed:<br>*They both entered the room without knocking on the resident's door.<br>*CNA E applied gloves to both hands without performing hand hygiene.<br>*CNA F applied gloves without performing hand hygiene.<br>*CNA E with her gloved hands performed the following tasks she:<br>-Had moistened the personal wipes with water and Aloe Vista cleansing foam.<br>*The bottle of Aloe Vista had fallen into the empty garbage can.<br>-Picked up the bottle of Aloe Vista out the garbage and then placed it on the sink.<br>-Removed resident 24's soiled incontinence brief and performed peri-care.<br>-Assisted CNA F rolling resident 24 from side to side and placed a new incontinence brief.<br>-Continued to assist CNA F and resident 24 with dressing.<br>-Had been touching resident 24's bedding.<br>*They each removed their gloves and then performed hand hygiene.<br>*CNA E applied the EZ lift strap around resident 24's waist. | F 880 | F880 continued<br><br>Monitoring:<br>4. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts for at least 4 weeks.<br>Monitoring for determined approaches to ensure effective implementation and ongoing sustainment.<br>*Staff compliance in the above identified areas.<br>*Any other areas identified through the Root Cause Analysis.<br>After 4 weeks of monitoring that demonstrates the expectations are being met, monitoring may reduce to twice monthly for at least one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and will be continued until the facility demonstrates sustained compliance as determined by the QAPI committee. | |

| 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 ______ | 10/19/2023 |

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

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|---|---|---|---|---|
| F 880 | Continued From page 3 | F 880 | | |

*She then begun to lift the resident up using the mechanical lift and then transferred her to her wheelchair.
*CNA E removed her gloves and applied an alcohol hand rub.
*She then made the resident's bed.
*CNA E wheeled the resident out of her room.
*CNA F had moved the EZ stand mechanical lift out into the hallway.
-They had not sanitized the lift after using it on resident 24.
*CNA F then wheeled the lift into resident 85's room.
*CNA E and CNA F attached the sling to resident 85's waist and transferred her to the toilet.

Interview with CNA E and CNA F following the above observations revealed:
*CNA E had not realized that she used the same gloves to perform peri-care and then assisted resident 24 to dress with those same gloved hands.
*CNA F had not realized that CNA E had not sanitized the lift between the use with resident 24 and 85.

Interview on 10/19/23 at 3:00 p.m. with registered nurse (RN) D regarding the above observations and interviews revealed:
*CNAs have been trained to sanitize the mechanical lifts between each resident use.
*She agreed that CNA E should have removed her gloves and performed hand hygiene after performing peri-care and the removal of the resident's soiled brief.

Interview on 10/19/23 at 4:04 p.m. with director of nursing (DON) B regarding the above observations and interviews revealed:

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|---|---|---|---|
| | 435094 | A. BUILDING ______ B. WING ______ | 10/19/2023 |

| 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 880 | Continued From page 4<br>*She agreed that CNA E should have changed gloves after performing peri-care and removing the resident's soiled brief.<br>*Mechanical lifts were to have been sanitized after each resident use.<br><br>Review of the provider's April 2023 Hand Hygiene (washing hands with soap and water or using an alcohol hand rub) policy revealed:<br>*"Before a clean procedure."<br>*"After removing gloves."<br><br>Review of the provider's October 2023 EZ Stand Operation Lifting/Transferring policy revealed:<br>*"Cleaning:"<br>-"EZ Stand harnesses are for single patient use only to avoid the risk of cross contamination".<br>-"EZ stand lift should be thoroughly wiped down with facility approved disinfectant, Allow to dry for a full minute before use." | F 880 | | |

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

PRINTED: 10/26/2023
FORM APPROVED
OMB NO. 0938-0391

| 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 ______ | 10/19/2023 |

| 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<br><br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 10/17/23 through 10/19/23. Wakonda Heritage Manor was found in compliance. | E 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Robin R. Stockland | Administrator | 10/30/2023 |

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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|---|---|---|---|
| | 435094 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **10/18/2023** |

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

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| K 000 | INITIAL COMMENTS<br><br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/18/23. Wakonda Heritage Manor was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.<br><br>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<br>SS=D | Multiple Occupancies<br>CFR(s): NFPA 101<br><br>Multiple Occupancies - Sections of Health Care Facilities<br>Sections of health care facilities classified as other occupancies meet all of the following:<br><br>o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access.<br>o They are separated from areas of health care occupancies by<br>construction having a minimum two hour fire resistance rating in<br>accordance with Chapter 8.<br>o The entire building is protected throughout by an approved, supervised<br>automatic sprinkler system in accordance with Section 9.7.<br><br>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of | K 131 | K 131<br><br>System correction: Maintenance director adjusted the latch on the fire door listed that is in the separation wall between the nursing and the assisted living on 10/26/2023. This door now closes and latches correctly in order to provide fire separation between the nursing home and assisted living.<br><br>System monitoring: Maintenance director or designee will conduct audits on all fire rated doors 1 time per week x 4 weeks, then monthly for 6 months with results from the audits to be reported at the monthly QAPI meeting by maintenance director or designee. If any problem is noted during audits, it will be fixed immediately. | 10/26/2023 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland
TITLE: Administrator
(X6) DATE: 11/01/2023

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|---|---|---|---|
| | 435094 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **10/18/2023** |

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

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|---|---|---|---|---|
| K 131 | Continued From page 1<br>patients served.<br>19.1.3.3, 42 CFR 482.41, 42 CFR 485.623<br>This REQUIREMENT is not met as evidenced by:<br>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 assisted living). Findings include:<br><br>1. Observation on 10/17/23 at 1:30 p.m. revealed the ninety-minute fire-rated door in the separation wall between the nursing home and the assisted living. Testing of that door at that same time reveled it did not close and latch on four of four attempts.<br><br>Interview with the maintenance assistant at the time of the observation and testing confirmed those findings.<br><br>The deficiency could affect 100% of the occupants of the smoke compartment. | K 131 | | |

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: ______<br>B. WING ______ | 10/19/2023 |

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

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|---|---|---|---|---|
| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/17/23 through 10/19/23. Wakonda Heritage Manor was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>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 10/17/23 through 10/19/23. Wakonda Heritage Manor was found in compliance. | S 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Robin R. Stockland | Administrator | 10/30/2023 |