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	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakonda Heritage Manor	515 Ohio Street Wakonda, SD 57073

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51471 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 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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-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 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 the chair with the control inside its side pocket. -The chair raised and lowered with the use of the control. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. -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. 49958 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: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*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. 14. Review of resident 21's EMR revealed: *She was admitted to the facility on [DATE]. *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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*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 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51370 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 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*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 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-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: *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.