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	05/07/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. 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. 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 (continued on next page)

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.

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the recliner in the lounge. Resident 6's care plan indicated that her feet were to always be down. 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 [NAME] LTC [long-term care] facility setting. This assures [NAME] restraint procedures are consistent, compliant, and provides reliable communication to all departments and [NAME] LTC facilities. Policy Scope: This policy will apply to all individuals implementing physical and/or chemical restraints at [NAME] 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. [NAME] entities are required to adopt [NAME] 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 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. 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, and other resources as available.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 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.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.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [NAME] ultra healing lotion, a bottle of [NAME] 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 [NAME] 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 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.