

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

ORIGINAL

PRINTED: 12/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2014
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
(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 Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/17/14 through 11/20/14. Jenkins Living Center was found not in compliance with the following requirements: F221, F225, F253, F323, and F431.	F 000	Addendums noted with an asterisk per 11/14 telephone to facility administrator. JTS/DDH/ME	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has 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. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to ensure periodic assessments had been completed for appropriate use of positioning bars on seven of seven sampled residents (1, 5, 8, 10, 12, 13, and 19). Findings include: 1. Random observations from 11/17/14 to 11/19/14 from 8:00 a.m. to 5:00 p.m. of resident 8's bed revealed two half-rails up on the top half of the bed. Review of resident 8's medical record revealed: *An admit date of 12/23/13. *A care plan that stated "Has assist bars(s) on the bed to help with positioning." *No initial or ongoing assessments to show	F 221	Resident's #5,8,12,13 and 19 have been assessed for appropriate use of positioning bars. Resident # 1 expired. Resident #10's assist bars have been removed. Care plans have been updated. All residents in the facility could potentially be affected by this deficiency. The Director of Nursing and members of the interdisciplinary team reviewed and revised the policy and procedure regarding assist bars. All staff responsible for the initial and ongoing assessment will be educated by the D.O.N. at a directed inservice on 12-16-14 regarding appropriate assessment and use. The Director of Nursing, or her designee, will perform audits of 4 residents weekly for 4 weeks, and then monthly for 3 months, to ensure that initial and ongoing assessments are completed. Results of the audits will be reported by the D.O.N. at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.	1-9-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Barth M. Williams

TITLE

Pres / CEO

(X6) DATE

12-12-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided that 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.

DEC 15 2014
SD DOH L&C

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F 221	<p>Continued From page 1 appropriate use of those half-rails had been done.</p> <p>Surveyor: 33488 2. Random observations on 11/17/14 and 11/18/14 of resident 1's bed revealed two assist bars on the top half of his bed.</p> <p>Review of resident 1's medical record revealed: *No assessment had been completed for the use of the assist bars. *The assist bars had not been documented on the care plan.</p> <p>3. Random observations on 11/17/14 and 11/18/14 of resident 10's bed revealed two assist bars on the top half of her bed.</p> <p>Review of resident 10's medical record revealed: *No assessment had been completed for the use of the assist bars. *The assist bars had not been documented on the care plan.</p> <p>Surveyor: 16385 4. Random observations from 11/17/14 through 11/19/14 of resident 5's bed revealed two raised assist bars attached to the upper half of her bed.</p> <p>Review of resident 5's medical record revealed there had been no assessment indicating a need for an assist rail.</p> <p>5. Random observations from 11/17/14 through 11/19/14 of resident 12's bed revealed two raised assist bars attached to the upper half of her bed.</p> <p>Review of resident 12's medical record revealed there had been no assessment indicating a need for an assist rail.</p>	F 221		

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F 221	Continued From page 2 6. Random observations from 11/17/14 through 11/19/14 of resident 19's bed revealed two raised assist bars attached to the upper half of her bed. Review of resident 19's medical record revealed there had been no assessment indicating a need for an assist rail. 7. Random observations from 11/17/14 through 11/19/14 of resident 13's bed revealed one raised assist bar attached to the upper half of his bed. Review of resident 13's medical record revealed there had been no assessment indicating a need for an assist rail. 8. Interview on 11/19/14 at 10:45 a.m. with the director of nursing (DON) revealed no formal assessment had been implemented for residents who had used the assist bars for repositioning in bed or for transfer in and out of bed. Review of the provider's February 2007 positioning devices policy revealed: **Positioning device assessment will be filled out by the RN's/LPNs or therapy when a device is being considered." *Side rails had not been mentioned as a positioning device.	F 221			
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225	No corrective action is indicated for residents #24,28,29,30,31, and 32* <i>as unable to change past events for those residents.</i> Any resident who experiences a report-able event could potentially be affected	12-16-14 <i>UT/DH/MF</i>	

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F 225	<p>Continued From page 3</p> <p>registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on record review, interview, and policy review, the provider failed to submit incident reports in a timely manner to the South Dakota Department of Health (SD DOH) for one of one</p>	F 225	<p>by this deficiency.</p> <p>The Director of Nursing and the interdisciplinary team reviewed and revised the abuse and neglect policy to ensure it includes defined event reporting which adheres to state and federal guidelines. ✓</p> <p>The Director of Nursing, or her designee, will review all reportable events weekly for a period of 4 weeks, and then monthly for 3 months to ensure timely reporting that adheres to state and federal guidelines. Results of the audits will be reported by the D.O.N. at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.</p> <p>Newly hired professional nursing staff will be educated on this policy by the staff development director at the time of orientation. JT/SDDOH/ME</p>		

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F 225	<p>Continued From page 4</p> <p>sampled resident (24) and five of five randomly selected residents (28, 29, 30, 31, and 32) with falls. Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 24's 6/24/14 incident report revealed: *A fall with serious injury had occurred. *SD DOH had been notified on 6/26/14. 2. Review of resident 28's 8/10/14 incident report revealed: *A fall with right hip pain had occurred. *SD DOH had been notified on 8/12/14. 3. Review of resident 29's 9/6/14 incident report revealed: *An unwitnessed fall with injury had occurred. *SD DOH had been notified on 9/8/14. 4. Review of resident 30's 10/2/14 incident report revealed: *An unwitnessed fall had occurred. *SD DOH had been notified on 10/6/14. 5. Review of resident 31's 11/4/14 incident report revealed: *An unwitnessed fall with injury had occurred. *SD DOH had been notified on 11/6/14. 6. Review of resident 32's 11/15/14 incident report revealed: *An unwitnessed fall with injury had occurred. *SD DOH had been notified on 11/17/14. 7. Interview on 11/19/14 at 3:25 p.m. with the director of nursing revealed she: *Was aware of one incident report being late but not the others. *Agreed the above incidents had not been 	F 225		

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F 225	Continued From page 5 reported to the SD DOH in the required time of twenty-four hours, or in the event of a serious injury within two hours. Review of the provider's September 2012 policy on Incident Reports revealed "All variances involving residents, including but not limited to misappropriation of property, falls, skin tears, bruises, medication errors or other injuries will be documented and reported, adhering to State and Federal guidelines."	F 225		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and instruction review, the provider failed to appropriately monitor the temperature for: *Two of two refrigerators located in residents 26's and 27's rooms. *Two of two refrigerators located in the lounge/activity area on the second and third floors. Findings include: 1. Random observations and interviews on 11/17/14 and 11/18/14 with residents 26 and 27 regarding their in-room refrigerators revealed: *The refrigerators were owned and brought to the facility by the residents. *There had been no thermometer in the residents'	F 253	* which included residents 26 and 27, JTSDDOHI/MF Residents with personal refrigerators were identified and thermometers were placed in those units. Daily temperature logs were also place by the resident lounge refrigerators cited in this deficiency. All residents could potentially be affected by this deficiency. * on 11/11/14 JTSDDOHI/MF The Director of Nursing and the interdisciplinary team reviewed and revised the policy and procedure for monitoring refrigerators to include personal refrigerators kept in resident rooms and resident lounge refrigerators. * see page 7. JTSDDOHI/MF The Environmental Services Director, or his designee, will audit refrigerator temperatures in resident care areas weekly for a period of 4 weeks, and then monthly for 3 months to ensure that: (1) temperatures are logged daily; (2) food and beverage items are labeled with "opened" dates; and (3) food expiration dates are monitored. Results of the audits will be reported by The Environmental Services Director, or his designee, at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.	1-9-15

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F 253	<p>Continued From page 6</p> <p>refrigerators. *They were not monitoring temperatures or outdates. *The provider had not: -Monitored and recorded temperatures of the refrigerators. -Labeled food or drink with appropriate opened dates. -Monitored expiration dates on food or drinks.</p> <p>2. Random observations on 11/18/14 of the refrigerators in the lounge/activity areas on the second and third floors revealed: *There were thermometers inside the refrigerators. *There were no logs to ensure the temperatures had been monitored daily.</p> <p>Interview on 11/18/14 at 12:45 p.m. with registered nurse (RN) B regarding the refrigerator on second floor in the lounge/activity area revealed she: *Was unsure whose responsibility it had been to monitor the refrigerators. *Was not aware of any staff member logging any temperatures on the refrigerators. *Reported the refrigerators held residents' items such as supplements and food from family members.</p> <p>3. Interview on 11/19/14 at 1:15 p.m. with the maintenance supervisor and the director of nursing (DON) regarding the refrigerators revealed: *They were unsure if any staff had ever checked the temperatures in resident 26's and 27's refrigerators. *They were unaware there had been no thermometers placed inside the refrigerators.</p>	F 253	<p><i>*(continued from page 6) Newly hired housekeeping and nursing staff will be orientated by their perspective department heads at the time of new hire orientation. JT/SDDH/mf</i></p>		

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F 253	Continued From page 7 *They agreed the temperatures needed to be checked and logged daily to ensure resident safety. Review of the provider's undated, unlabeled refrigerator instructions revealed: *Temperatures needed to be checked and logged daily. *Nursing was responsible to check and log temperatures in the lounge/activity areas on second and third floors. *There was no mention of responsibilities that included residents personal refrigerators kept in their rooms.	F 253	Safety tabs were installed on all EZ-Stand lifts.	12-16-14	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on observation, interview, and review of the manufacturer's operating instructions, the provider failed to ensure eleven randomly observed EZ Stand lifts (mechanical lifts used for transferring residents) had safety tabs per manufacturer's instructions. Findings include: 1. Random observations from 11/17/14 through 11/19/14 revealed eleven EZ Stand mechanical	F 323	All residents using EZ-Stand lifts in the facility could potentially be affected by this deficiency. The Administrator, Director of Nursing, and Environmental Services Director reviewed and revised the policy and procedure regarding assessing and ensuring the safe use of the EZ-Stand lifts. All nursing staff will be educated by the D.O.N. at a directed inservice on December 16, 2014 regarding responsibility and accountability for safe use of the EZ-Stand lifts. * see page 9. JTS/DOH/ME The Director of Nursing, or her designee, will perform audits of all EZ-Stand lifts weekly for a period of 4 weeks, and then monthly for 3 months to ensure that safety tabs are in place. Results of the audits will be reported by the D.O.N. at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.		

*12/17/14
JTS/DOH/ME*

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F 323	Continued From page 8 lifts had no safety tabs attached to the harness attachment area. Those safety tabs were to ensure the sling loops were secured within the harness hookup, so residents would not have fallen from the mechanical lift. Interview on 11/19/14 at 3:30 p.m. with the environmental services director confirmed the safety tabs had not been in place. He had not received any repair notifications for the tabs not in place. Review of the provider's EZ Stand Operating Instructions safety and maintenance checklist revealed: **The manufacturer suggests that the following components and operating points be scheduled for inspection at intervals not greater than one month. Any detected deficiency must be rectified before the device is put back into service." **5) Safety tabs need to be checked to make sure they are in place."	F 323	* (continued from page 8) Newly hired nursing staff members will be orientated by the staff development director at time of new hire orientation. JTSDDH/ME		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	Resident #33's medication cards have been reconciled. The medication room refrigerator/freezers cited in the findings have been defrosted. All residents in the facility could potentially be affected by this deficiency. The Director of Nursing, in collaboration with the Pharmacist consultant, reviewed and revised the policy and procedure regarding administration of regularly scheduled medications, which include Schedule III-V controlled medications. The D.O.N. and interdisciplinary team reviewed and revised the policy and procedure regarding medication room refrigerators to include responsibilities for defrosting	1-1-15	

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F 431	<p>Continued From page 9</p> <p>instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to: *Have a system of accountability and reconciliation for regularly given controlled medications (Schedule III-V narcotic medications). *Ensure two of five medication (med) room refrigerator/freezers located in the second floor middle nurses station med room and third floor secured unit medication room had been defrosted. Findings include:</p> <p>1. Observation on 11/19/14 at 9:00 a.m. with licensed practical nurse (LPN) A of the</p>	F 431	<p>those units. All staff responsible for administering medications and defrosting medication room refrigerator/freezers will be educated by the D.O.N. at a directed inservice on December 16, 2014 regarding accountability and reconciliation of controlled medications, as well as proper maintenance of medication room refrigerators. ✕</p> <p>The D.O.N., or her designee, will perform audits of 4 residents weekly for a period of 4 weeks, and then monthly for 3 months, to ensure appropriate accountability and reconciliation of controlled medications. The Director of Nursing, or her designee, will perform audits of 1 medication room refrigerator weekly for a period of 4 weeks, and then monthly for 3 months to ensure that appropriate maintenance is being completed. Results of the audits will be reported by the D.O.N. at monthly QAPI Committee meetings for 3 months, with additional follow-up as recommended by the Committee.</p> <p><i>Newly hired professional nursing staff will be educated on these policies by the staff development director at the time of orientation.</i> JT/SDD/HMF</p>		

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F 431	<p>Continued From page 10</p> <p>medication cart located on the secured unit on second floor revealed:</p> <p>*Four blister packs (pre-packaged medication) of regularly given clonazepam (anti-anxiety medication) for resident 33. Tablets remaining were:</p> <ul style="list-style-type: none"> -Blister pack one had twenty-seven of thirty half-tablets remaining. -Blister pack two had twelve of thirty half-tablets remaining. -Blister pack three had thirty of thirty half-tablets remaining. -Blister pack four had nine of thirty half-tablets remaining. <p>*Medication instructions written on the blister packs were to "Give ½ tablet by mouth two times daily (in the am and at noon) ...Give ½ tablet by mouth every evening as needed."</p> <p>Interview on 11/19/14 at 2:00 p.m. with the director of nursing (DON) regarding the above blister packs for resident 33 revealed she agreed:</p> <ul style="list-style-type: none"> *She was unable to explain why the amounts of medication in each blister pack varied. *They did not have a system to account for regularly given scheduled III-V controlled narcotic medication. *Without a system of reconciliation or inventory, they would have no way of knowing how much of a regularly given controlled medication should be in the blister packs. <p>Review of the provider's 12/1/7 LTC (long term care) Facilities Receiving Pharmacy Products and Services from Pharmacy policy revealed after taking delivery, the provider should have immediately logged all controlled substances into their inventory.</p>	F 431			

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

PRINTED: 12/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2014
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(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 431	<p>Continued From page 11</p> <p>2. Observation on 11/19/14 of the medication room refrigerators located on the second and third floor medication rooms revealed thick ice buildup was present in both refrigerators freezers.</p> <p>Interview on 11/19/14 at 12:45 p.m. with registered nurse B regarding the second floor medication room refrigerator used to store residents' medications revealed: *She had been unaware of the frost and ice build-up in the refrigerator's freezer. *Agreed several inches of frost had built up on the inside of the freezer. *She was unaware who was to have been responsible to clean and defrost the medication room refrigerators. *She agreed the refrigerator freezers needed to be defrosted.</p> <p>Interview on 11/19/14 at 1:15 p.m. with the DON regarding the above refrigerator freezers revealed she: *Had been unaware the above refrigerator freezers needed to be defrosted. *Agreed frost build-up on the inside of the freezer would make it hard to maintain the correct temperature.</p> <p>Review of the provider's undated, unlabeled, refrigerator policy revealed nurses were responsible to clean and defrost refrigerators located in the medication rooms.</p>	F 431			

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

ORIGINAL

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
(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 Surveyor: 21301 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/19/14. Jenkins Living Center (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 11/21/14 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K029 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	A door closing device was installed on the storage room door cited in finding #1 on 12-10-14. It was found that a sprinkler head was present in the dietary office storage room cited in finding #2, but it was obstructed by items stacked in front of it. The contents of the storage area have been rearranged to ensure clear access to the sprinkler head. A door closing device has also been added to the door which allows access to the cited storage area. All residents could potentially be affected by this deficiency. The Environmental Services Director will conduct audits weekly for a period of 4 weeks, and then monthly for 3 months, to	12-10-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John M. [Signature]

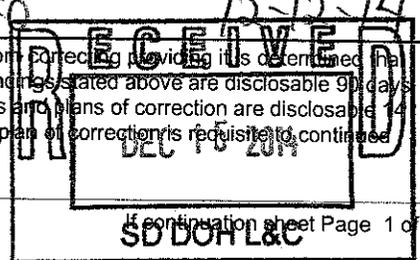
TITLE

Pres/CEO

(X6) DATE

12-12-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
(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 029	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 21301 Based on observation and interview, the provider failed to maintain proper separation of two randomly observed hazardous areas. The storage room located on the first floor in building 1A was not provided proper separation. The storage area located under the stairwell in the first floor dietetic office was not provided with a proper separation. Findings include: 1. Observation at 9:00 a.m. on 11/19/14 revealed a room containing miscellaneous combustible materials located on the floor and on a shelving unit. The room was larger than fifty square feet in area and was protected with an automatic fire extinguishment system. Further observation revealed the door to that room was not equipped with a self-closing or automatic closing device. Interview with the maintenance supervisor at the time of observation confirmed this room had no other function than for storage. 2. Observation at 9:15 a.m. on 11/19/14 revealed an area under a stairwell in the dietetic office. That area did not have a door separating it from the dietetic office. That area contained a large amount of papers and other combustible items. Further investigation revealed that it was not protected with an automatic fire extinguishing system. Exit interview with the administrator, assistant administrator, and the maintenance supervisor indicated that small area could be cleaned out and walled off to avoid extending the fire sprinkler piping into that area.	K 029	ensure that door closers are present in appropriate areas and that sprinkler heads are unobstructed. The Environmental Services Director will report results of the audits at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.	
K 034 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD	K 034		F

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NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(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 034	<p>Continued From page 2</p> <p>Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 21301</p> <p>Based on observation and record review, the provider failed to provide conforming exit stairs for one of three exit stairs (west stair) that did not have a landing. Findings include:</p> <p>1. Observation at 10:00 a.m. on 11/19/14 revealed the west stair connecting the first and second level was not provided with a landing at the second level. Record review of previous survey data confirmed the landing was not provided at the second level.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.</p>	K 034			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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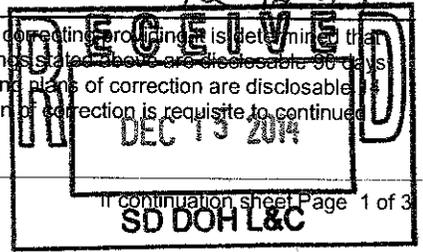
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 21301 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/19/14. Jenkins Living Center (Building 02) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 11/21/14 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 034 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 21301 Based on observation and record review, the provider failed to ensure conforming exit stairs for two of two stairs (east and west stairs) were not conforming. Findings include:</p> <p>1. Observation at 11:00 a.m. on 11/19/14</p>	K 034		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Barb M. Williams</i>	TITLE <i>Pres/CEO</i>	(X6) DATE <i>12-12-14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continue program participation.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
(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 034	Continued From page 1 revealed the door swinging into the second floor west stair enclosure reduced the landing to 21 inches. Observation at 11:15 a.m. on 11/19/14 also revealed the door swinging into the second floor east stair enclosure reduced the landing to 11 inches. Document review of previous survey data confirmed the condition.	K 034		
K 069 SS=D	The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 21301 Based on observation, document review, and interview, the provider failed to conduct the required inspection of the kitchen range exhaust ductwork. Inspections of the range hood exhaust ductwork must be conducted no less than annually (more frequently if needed based on findings). There was no documentation indicating the exhaust system had been inspected. Findings include: 1. Observation at 9:30 a.m. on 11/19/14 revealed the kitchen exhaust hood located above the deep fat fryer had a visible build-up of grease on the hood filters. Document review of the undated kitchen hood fire extinguishment system inspection revealed a note that stated the ductwork needs professional cleaning. There was	K 069	Dietary staff cleaned the kitchen exhaust hood filters on 12-11-14. The Environmental Services Director has begun contacting professional firms that are capable of cleaning the kitchen exhaust hood ductwork. A contract will be in place for the work by 1-9-15, and the actual work will take place as soon as possible. All residents could potentially be affected by the findings for this deficiency. The Environmental Services Director will conduct audits of the kitchen exhaust hoods weekly for a period of 4 weeks, and then monthly for 3 months, to ensure that range hood filters are cleaned appropriately, and that the exhaust system is professionally cleaned and inspected annually or as needed. Results of the audits will be reported by the Environmental Services Director at monthly QAPI Committee meetings for 3 months, with additional follow-up as recommended by the Committee.	1-9-15

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NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
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K 069	Continued From page 2 no documentation indicating the exhaust ductwork had been inspected for cleanliness/grease build-up. Interview with the maintenance supervisor revealed he was unaware the exhaust hood ductwork needed an annual inspection. At the exit interview the maintenance supervisor stated that the ductwork had been cleaned by the facility staff but he could not remember when it had been completed and did not have any documentation of that cleaning.	K 069			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201
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(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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K 000	INITIAL COMMENTS Surveyor: 21301 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/19/14. Jenkins Living Center (Building 03) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K029 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 21301 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas for the soiled utility room for one of one soiled utility rooms on the second floor. Findings	K 029	The louvered part of the soiled utility room door cited in finding #1 will be covered to provide the appropriate smoke protection. All residents could potentially be affected by the findings for this deficiency. The Environmental Services Director will conduct audits on all louvered doors in the facility monthly for a period of three months to ensure that the louvered portions of the doors are covered to provide appropriate smoke protection. Results of the audits will be reported by the Environmental Services Dir. at monthly QAPI Committee meetings for 3 months, with additional follow-up as recommended by the Committee.	12-19-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Forth M. Wilkerson</i>	TITLE <i>Pres CEO</i>	(X6) DATE <i>12-12-14</i>
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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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If continuation sheet Page of 2
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PRINTED: 11/24/2014
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(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 029	Continued From page 1 include: 1. Observation at 11:15 a.m. on 11/19/14 revealed a soiled utility room on the second floor secured unit. That room had a louver in the door. That door is not a smoke resisting door, because the louver would allow the passage of smoke. The room was provided with automatic fire sprinkler protection, and the door was provided with a door closing device. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He indicated that door had always been equipped with a louver.	K 029			

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NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 21301 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/19/14. Jenkins Living Center (building 04) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Forth H. Wilkman

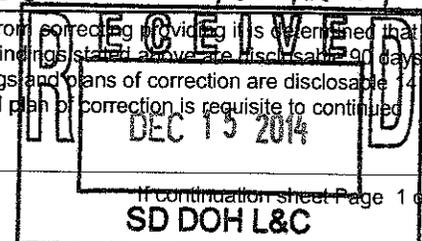
TITLE

Pres/CEO

(X6) DATE

12-12-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting if 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 45 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BUILDING 05 B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 21301 A recertification survey for compliance with the Life Safety Code(LSC) (2000 new health care occupancy) was conducted on 11/19/14. Jenkins Living Center (building 05) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John M. Wilkman

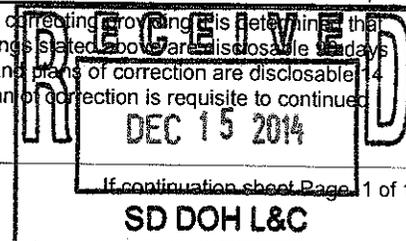
TITLE

Pres CEO

(X6) DATE

12-12-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it determines that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 14 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: 10703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2014
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NAME OF PROVIDER OR SUPPLIER JENKIN'S LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 S MAPLE ST WATERTOWN, SD 57201
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(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
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S 000	Initial Comments Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 11/17/14 through 11/20/14, Jenkins Living Center was found not in compliance with the following requirement: S216.	S 000		
S 216	44:04:04:07.01 ADMISSION-COMMUNICABLE DISEASES A resident who is infected with a communicable disease which is reportable to the department, pursuant to SDCL 34-22-12, may be admitted to a nursing facility if the appropriate infection control measures can be provided by the facility to prevent the spread of the communicable disease. The following specific diseases do not preclude a patient from being admitted to a nursing facility: acquired immune deficiency syndrome (AIDS), human immunodeficiency virus positive (HIV+), viral hepatitis, herpes (genital), leprosy, malaria, syphilis (late latent only), infection with antibiotic resistant organisms, and tuberculosis (noninfectious). If the nursing facility chooses to admit residents with these diseases or antibiotic resistant organisms, the following conditions must be met: (1) Nursing facility staff must complete a training program in infection control applicable to the diseases listed in this section or antibiotic resistant organisms; (2) The nursing facility must have written procedures and protocols for staff to follow to avoid exposure to blood or body fluids of the affected residents; and (3) The nursing facility must have written infection control procedures in place and practiced that	S 216	Resident # 20's physician determined that there was no active infection, and the resident discharged home on 11-19-14. All residents in the facility could potentially be affected by this deficiency. The Director of Nursing and Infection Control Coordinator reviewed and revised the policy related to admission of residents with past history of tuberculosis, and the prevention of possible infections if TB is identified in a resident after admission. The Infection Control Coordinator, or her designee, will perform audits of 4 residents weekly for a period of 4 weeks, and then monthly for 3 months to ensure appropriate screening of residents for TB, or absence of the disease, as determined by the physician. Results of the audits will be reported by the D.O.N. at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.	12-16-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John A. Williams

TITLE
Pres/CEO

(X6) DATE

RECEIVED

If continuation sheet 1 of 1

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South Dakota Department of Health

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S 216	<p>Continued From page 1</p> <p>prevent the spread of antibiotic resistant organisms.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33488 Based on observation, record review, and interview, the provider failed to ensure a system of preventative measures were in place for infection control after one of one resident (20) had been admitted with a history of tuberculosis (TB) (contagious lung infection). Findings include:</p> <p>1. Observation and interview on 11/18/14 at 8:50 a.m. with registered nurse (RN) C administering intravenous (IV) antibiotics to resident 20 revealed: *She had an active cough. *RN C: -Wore gloves but had not worn a mask or gown while she administered the IV medication. -Was in close contact with the resident. -Would go on to care for several other residents on her wing throughout her duties that day. -Stated the resident was at the facility short term and had been receiving treatment for a lung infection. -Stated the resident was expected to be discharged home following the completion of her IV antibiotics the next day.</p> <p>Review of resident 20's medical record revealed: *She had been admitted on 11/11/14 *She had been diagnosed with facility acquired pneumonia (lung infection) and required IV antibiotics. *She was a positive reactor for tuberculosis and had a history of the disease. *A fax to the primary care physician on 11/12/14 stated "...Also she is a known TB reactor. Do the</p>	S 216		

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S 216	<p>Continued From page 2</p> <p>chest x-rays r/o (rule out) active TB yes/no?" No had been circled, the fax signed by the physician, and faxed back to the provider.</p> <p>*A progress note from the hospital dated 11/10/14 listed the following diagnoses:</p> <ul style="list-style-type: none"> -Acute and chronic respiratory failure. -Left upper lobe pneumonia (top part of the lung). -End stage chronic obstructive pulmonary disease (the last stage in the progression of the disease before death causing increased difficulty in breathing). <p>Interview on 11/18/14 at 3:30 p.m. with the infection control coordinator regarding resident 20 revealed:</p> <p>*She had faxed the provider the information regarding the resident's history of tuberculosis.</p> <p>*She stated she had figured since he had said she "had not had active TB a few months ago it (health status) was okay".</p> <p>*When asked what the facility's protocols were regarding follow-up and preventative measures she replied, "We don't really have any written down. We just follow the state regulation (44:04:04:08.01)."</p> <p>*The facility had no written policy or instructions for staff concerning:</p> <ul style="list-style-type: none"> -Follow-up investigation needed by staff after receiving the fax identifying the possibility of a resident who might have active TB. -What measures should have been taken to ensure staff and resident safety in the presence of a resident with a potential TB infection with known symptoms. <p>*She agreed:</p> <ul style="list-style-type: none"> -She should have followed up with the physician for guidance. -Residents and staff would be at risk for contracting TB if the resident was determined to have active TB. 	S 216		

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S 216	<p>Continued From page 3</p> <p>-The provider needed to have a system in place to prevent possible infections if TB had been identified in a resident after admission.</p> <p>-The provider had no infection control policy related to admission of a resident or residents with past histories of tuberculosis.</p> <p>Interview on 11/19/14 at 10:00 a.m. with the director of nursing regarding resident 20 revealed she agreed:</p> <p>*Follow-up should have been conducted to determine if there had been a risk to staff and residents.</p> <p>*She was unsure what the policy had been specifically for infection control and TB.</p> <p>A copy of the state regulation 44:04:04:08.01 regarding tuberculin screening requirements given to this surveyor from the infection control coordinator, that she reported they had adopted to follow as their policy revealed:</p> <p>*The facility should have developed criteria to screen workers and residents for TB.</p> <p>*Policies and procedures should have included key components of responsibility, surveillance, containment, and education.</p> <p>*Presence or absence of the disease should have been determined by the physician.</p>	S 216		