

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 C 08/31/2016
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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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F 000	INITIAL COMMENTS Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/29/16 through 8/31/16. Jenkins Living Center was found not in compliance with the following requirements: F176, F280, F309, F314, F333, F368, and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/29/16 through 8/31/16. Areas surveyed included nursing services, admission, transfer, discharge rights, rehabilitation services, dietary services. Jenkins Living Center was found in compliance.	F 000	*Addendums noted with an asterisk per 9/29/16 per telephone with facility DON and administrator: CS/SDDOHL/EL	
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to ensure: *A physician's order was obtained for self-administration of medications for two of three sampled residents (3 and 25). *Assessments were completed for three of three sampled residents who self-administered medications (3, 9, and 25). Findings include:	F 176	The option to self-administer medications was assessed and/or offered to residents # 3, 9, and 25 upon admission. A self-administration assessment was completed on 9/20/16 for resident #9. A physician order was already in place for nasal spray, and the assessment will be done quarterly. Nurse I was re-educated regarding self-administration of medication policy on 9/15/16. All residents who receive medications could potentially be affected by this deficiency. All staff members that pass medications were provided directed in-service education on 9/20/16 regarding the Self-administration of Medication policy and procedure, which includes adding the Self-Administration order to the	10-13-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Barbara M. Williams</i>	TITLE <i>Pres CEO</i>	(X6) DATE <i>9-23-16</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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F 176	Continued From page 1 1. Observation on 8/30/16 at 4:45 p.m. during an interview with resident 3 revealed: *An unidentified staff member entered the room and placed a small cup with four pills in it on her bedside table. *The staff member explained them to the resident when she had asked. *She left the room before the resident had taken the medication. *The medication remained in the cup throughout the interview. Review of resident 3's medical record revealed: *She was admitted on 12/9/14. *Her 5/31/16 Minimum Data Set quarterly assessment indicated no memory impairment. *On 12/9/14 she had signed a form indicating she would like nursing staff to maintain and administer all of her medications. *An assessment was completed on 12/30/14 by nursing staff indicating she would like to self-administer medications and was capable of the task. *No physician's order to self-administer medications was found. *No additional assessments could be located in the medical record. *There was no information in the care plan regarding her self-administering medications. Interview on 8/31/16 at 1:45 p.m. with the director of nursing regarding resident 3 revealed: *She did not have a physician's order to self-administer her medications. *No annual or quarterly assessments had been completed. *It was her expectation the above resident had a physician's order and assessments completed	F 176	Physician Orders (which are reviewed every 90 days). The Float Nurse, or her designee, will audit 5 current resident medical records per week until all current resident medical records have been audited to ensure that a quarterly Self-Administration of Medications Assessment is completed, or there is documentation that the resident does not wish to self-administer medications. Physician orders will be obtained for those residents deemed appropriate for self-administration of medications. Results of the audits will be reported by the Director of Nursing at monthly QAPI Committee meetings for review and recommendation.		

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F 176	<p>Continued From page 2</p> <p>prior to self-administration of medications. Surveyor: 34030</p> <p>2. Observation and interview on 8/30/16 at 11:15 a.m. with registered nurse I during medication pass in the Wrage Special Care unit revealed: *She set resident 25's medications in a medication cup beside her at the table during meal service. *The resident took the medication. *RN I verified resident 25 had neither been assessed for the ability to take her own medications nor had a physician's order to do so. Surveyor: 18560</p> <p>3. Review of resident 9's medical record revealed: *An order for saline nasal spray on her August 2016 Medication Administration Record. *The order noted she could self-administer the nasal spray. *A self-administration of medication assessment had last been completed on 5/14/13.</p> <p>Interview on 8/30/16 at 11:30 a.m. with the DON confirmed a self-administration of medications assessment should have been completed for resident 9 quarterly.</p> <p>4. Review of the provider's March 2009 Medication Self-Administration policy revealed: *The care team would evaluate the resident's mental competence to determine if the resident could safely self-administer medications. *A physician's order for self-administration of medications would be obtained if the resident was found to be safe to administer medications. *Self-administered medication would be listed on the medication sheet. *The nurse would complete weekly assessments on the resident's ability to self-administer</p>	F 176			

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F 176	Continued From page 3 medications.	F 176			
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure 1 of 21 sampled residents (12) had a care plan that was individualized to her specific needs. Findings include:</p> <p>1. Review of resident 12's entire medical record revealed:</p>	F 280	<p>The care plan for resident #12 did include specific interventions to manage blood sugar parameters, including when to notify the physician and a toileting plan to address incontinence.</p> <p>All residents could potentially be affected by this deficiency.</p> <p>Staff persons responsible to develop care plans have been re-educated regarding care plan policy and procedure.</p> <p>The Medicare Coordinator, or her designee, will audit current resident care plans per week until all current resident care plans have been audited to ensure the care plans meet the residents' needs pertaining to falls, diabetes, and behaviors. Results of the audits will be reported by the Director of Nursing at monthly QAPI meetings for review and recommendation.</p> <p><i>*and continue to update care plans per care conference schedule. CS/SDDOH/EL</i></p>	10/13/16	

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F 280	<p>Continued From page 4</p> <p>*Her original admission date was 11/21/12. *She had been admitted to the hospital on 4/28/16 related to uncontrolled diabetes. *Her diagnoses included: delusional disorders, Alzheimer's disease, and Type 2 diabetes with hyperglycemia. *Physician's orders dated 8/29/16 included: -Checking her blood glucose level four times a day. -Receiving insulin based on her carbohydrate intake at meals. -Receiving a sandwich and milk every evening before bedtime. -Placement in a secured dementia unit due to wandering. *Her medications included an antipsychotic medication for paranoid delusion.</p> <p>Review of resident 12's weight record revealed: *They were checked four times a day. *On 2/6/16 she weighed 143 pounds (lb). *On 4/22/16 she weighed 146 lb. *On 5/27/16 she weighed 141 lb. *On 6/24/16 she weighed 147 lb. *On 7/29/16 she weighed 150 lb. *On 8/26/16 she weighed 152 lb.</p> <p>Review of resident 12's August 2016 blood glucose level record revealed: *Her blood sugars had ranged from 36 to 558. *Her blood sugars had been below 100 twenty-six times. *Her blood sugars had been over 300 twenty-one times.</p> <p>Review of resident 12's incident reports revealed she had fallen sixteen times between 2/19/16 and 6/25/16. Further review revealed: *Most times when she fell she said she had</p>	F 280		

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F 280	<p>Continued From page 5 become dizzy. *She did not have any injuries with the falls. *Following a review by the pharmacist on 6/29/16 the antipsychotic medication dose had been reduced. -He thought her falls might be related to that medication. -The physician agreed with the recommendation. *She had one fall following the change in medication.</p> <p>Interview on 8/20/16 at 4:00 p.m. with licensed practical nurse (LPN) J regarding resident 12 revealed: *They had changed her carbohydrate count at supper about a month ago because of her blood sugar levels. *She thought the day shift might have changed theirs too, but she did not know for sure. *She confirmed her blood sugars varied greatly. *They had added a snack when her blood sugars were low, but she did not know what that measure for 'low' was. *She was resistant to cares, especially bathing. *She confirmed she had fallen many times. -She was usually by her bed when she fell. -She got up so fast, and then she would fall.</p> <p>Review of resident 12's 6/16/16 care plan revealed she: *"Was a brittle diabetic". *Had fluctuating blood sugars and became dizzy at times because of that. *Took strong medicine for her depression and dementia with behaviors. *Was incontinent at times. *Had a risk for falling. *Could be resistant to care. *The care plan did not address specific</p>	F 280			

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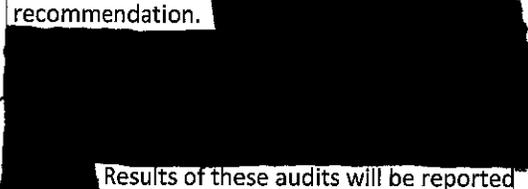
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F 280	Continued From page 6 interventions: -To manage her blood sugars. -Specific blood sugar parameters, including when to notify her physician. -For the behaviors she exhibited, including at bath time. -A specific plan to manage her behaviors, including bath time. -How they prevented falls. -A toileting plan to prevent incontinence. Review of the provider's October 2015 Resident Centered Care Plan Facility Standards policy revealed: *"Care plans are written by exception and include measurable outcomes and identify interventions that are specific to the individual resident with defined time frames or parameters. *The care plan is reviewed and/or revised after each assessment and PRN [as needed]." *The policy did not address how they incorporated individual approaches into the care plan.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 34030	F 309	A therapy screen was completed for resident #5 on 9/20/16. Interventions, as resident allows, have been put into place to ensure proper body alignment for resident #5. All residents could potentially be affected by this deficiency. Direct care staff were re-educated on 9/20/16 and 9/22/16 regarding how to identify residents who may need a therapy screen to address positioning, and the use of assistive devices to ensure proper positioning. Re-education of direct care staff on those same dates addressed	10/13/16	

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F 309	<p>Continued From page 7</p> <p>Based on observation, interview, and record review, the provider failed to:</p> <ul style="list-style-type: none"> *Ensure correct body positioning for one of three sampled residents (5). *Assist with dining for one of six sampled residents (5) and one of one randomly observed resident (26). <p>Findings include:</p> <p>1. Random observations from 2:30 p.m. to 6:30 p.m. on 8/29/16, and from 8:00 a.m. to 5:30 p.m. on 8/30/16 of resident 5 revealed:</p> <ul style="list-style-type: none"> *She resided in the Wrage Special Care area. *She was seated in a rocking wheelchair with a high back. *She was slumped over to her right side in this chair. *She was unable to sit upright by herself. -No wedges or pillows were used to help position her. *The head of her chair was a good foot above her head and did not support it. *She was in that chair for her meals and during the day. <p>Review of resident 5's medical record revealed:</p> <ul style="list-style-type: none"> *She was admitted on 7/24/15. *She had diagnoses of dementia with a history of a stroke. *She had lost weight but her weight had recently stabilized. <p>Review of resident 5's 6/29/16 Minimum Data Set (MDS) assessment revealed:</p> <ul style="list-style-type: none"> *Her Brief Interview of Mental Status (BIMS) assessment score was five which showed severe mental impairment. *She used a wheelchair and was assisted by staff to get around. 	F 309	<p>providing assistance to residents at meal times as directed by the plan of care.</p> <p>The Therapy Manager, or her designee, will audit 5 random residents to ensure proper wheelchair seating and positioning. Audits will be completed weekly for 4 weeks, and then monthly for 3 months. Results of the audits will be reported by the Therapy Manager at monthly QAPI Committee meetings for review and recommendation.</p> <p></p> <p>Results of these audits will be reported by the Director of Nursing at monthly QAPI Committee meetings for review and recommendation.</p> <p><i>*The assistant Director of Nursing or her designee, will audit each resident dining room weekly, including observations of resident 5 and 26 for 4 weeks and then monthly for 3</i></p>	
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F 309	<p>Continued From page 8</p> <p>*She needed extensive assistance of one to two staff members to transfer.</p> <p>*She needed extensive physical assistance of one staff member to eat.</p> <p>Interview on 8/31/16 at 11:00 a.m. with registered nurse (RN) I regarding resident 5's wheelchair revealed:</p> <p>*At some point resident 5 was changed from a regular wheelchair to her current one, because the old one did not fit her.</p> <p>*She could not tell me when it was changed and could not find it in the resident's records.</p> <p>*She thought perhaps physical therapy had assessed it and suggested the change.</p> <p>Interview on 8/31/16 at 2:30 p.m. with physical therapist L regarding resident 5 revealed he:</p> <p>*Was unaware resident 5 had problems with positioning.</p> <p>*Had not been notified of that by the nursing staff nor was he aware she was using a rocking wheelchair.</p> <p>*He agreed if she was seated in a wheelchair and was leaning over to the side in it some adjustments should have been made to ensure proper positioning.</p> <p>2a. Observations on 8/29/16/ of the evening meal in the Wrage Special Care area revealed:</p> <p>*Resident 5 was seated at the middle of three tables in the dining room with three other residents.</p> <p>-She was seated in a rocking wheelchair with a high back.</p> <p>-She was slumped over to her right side in that chair.</p> <p>-She ate by herself at the start of the meal. She would eat a few bites then stop.</p>	F 309	<p>*months to ensure residents are receiving assistance during meals as directed in their plan of care.</p> <p>CS/SDDO/H/EL</p>	
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F 309	<p>Continued From page 9</p> <p>-She appeared to have difficulty eating due to her positioning and lost interest in her food.</p> <p>-She was assisted to eat by the director of nursing (DON) for around five minutes before she left to assist another resident.</p> <p>-Intake for resident 5 was one half of her dessert and a few bites of her hamburger.</p> <p>Observation on 8/30/16 of the noon meal in the Wrage Special Care area revealed:</p> <p>*Resident 5 was seated at the same table and in the same position as last evening.</p> <p>*She ate by herself and took about three quarters of her meal.</p> <p>*At one point she was having difficulty with her meal and was assisted by another resident's family member.</p> <p>*No staff had assisted her beyond meal set up.</p> <p>Review of resident 5's medical record and MDS are as in finding number one above.</p> <p>Review of resident 5's 7/15/16 care plan revealed she needed "1 assist" of staff to eat.</p> <p>b. Observation on 8/29/16 of the evening meal in the Wrage Special Care area revealed:</p> <p>*Resident 26 was seated at the far table with six other residents.</p> <p>*He sat at the table with his food in front of him from 5:15 p.m. until 5:45 p.m. without eating.</p> <p>*At 5:45 p.m. an unidentified staff member sat with him to assist him to eat.</p> <p>*His food had not been re-warmed.</p> <p>Review of resident 26's medical record revealed:</p> <p>*He was admitted on 7/5/16.</p> <p>*Diagnoses that included non-Alzheimer's dementia.</p>	F 309		
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F 309	<p>Continued From page 10</p> <p>Review of resident 26's 7/13/16 MDS assessment revealed: *BIMS score of ninety-nine which indicated he was unable to complete the assessment. *Staff had completed the assessment and had determined: -He had memory problems. -His cognition was severely impaired. -His mobility and functioning were severely impaired. *He needed extensive physical assistance of one staff person to eat.</p> <p>Review of resident 26's 7/20/16 care plan revealed he needed "1 assist" of staff to eat.</p> <p>c. Interview on 8/30/16 at 11:45 a.m. with the director of quality assurance (who was in the dining hall for the noon meal) regarding assistance of residents revealed: * "Sometimes we have volunteers come in to help, but not always." * "Especially not in the evenings" [are there volunteers to help with feeding the residents].</p> <p>Interview on 8/30/16 at 11:50 a.m. with RN I regarding resident 26 revealed all residents seated at that table required assistance to eat.</p> <p>Interview on 8/30/16 at 2:30 p.m. with certified nursing assistant M regarding resident 5 revealed she was assisted with eating "depending on the day."</p> <p>Interview on 8/31/16 with the director of nursing regarding both the positioning of resident 5 and meal assistance for residents 5 and 26 revealed: *She was unaware of resident 5's positioning in</p>	F 309		

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F 309	Continued From page 11 her current wheelchair. *She agreed eating assistance had not been consistently provided for residents 5 and 26. *No policies regarding the above existed.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, record review, interview, and guideline review, the provider failed to ensure a pressure ulcer was properly identified, the physician notified, and appropriate treatment initiated for one of three sampled residents (16) with a pressure ulcer. Findings include: 1. Observation on 8/31/16 at 8:15 a.m. of resident 16 revealed: *He was seated in his wheelchair at the breakfast table on the second floor. *There was a pressure reducing device on the seat of his chair. Review of resident 16's medical record revealed: *He was admitted on 10/14/14. *He had diagnoses including diabetes, coronary	F 314	There is no corrective action to be taken for resident #16 because the open area was found to be healed during the survey. All residents could potentially be affected by this deficiency. Direct care staff responsible for care and services to address alteration in skin integrity were re-educated about the need to inform the Physician regarding the development of an open area, and to obtain a physician's order to treat an open area. Staff were also re-educated on the scope of practice requiring a Registered Nurse to assess a pressure ulcer. The Director of Nursing, or her designee, will audit the medical record of 3 residents with open areas to ensure physician notification, treatment plan, and that assessment has been done by an RN. Audits will be completed weekly for 4 weeks, and then monthly for 3 months. Results of the audits will be reported by the Director of Nursing at monthly QAPI meetings for review and recommendation.	10/13/16	

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F 314	<p>Continued From page 12</p> <p>artery disease, and history of pressure ulcers. *No Braden skin assessment had been done to assess his risk for skin breakdown.</p> <p>Review of resident 16's 8/24/16 Minimum Data Set (MDS) assessment revealed he: *Had a Brief Interview for Mental Status assessment score of twelve that showed mild cognitive impairment. *Was incontinent of bowel and wore disposable products. *Was unable to walk and used a wheelchair. *Had a stage two pressure ulcer. *Earlier MDS assessments showed him to be at risk to develop pressure ulcers and the appropriate interventions were in place.</p> <p>Review of resident 16's current treatment administration record revealed no specific treatment was being done for a pressure ulcer.</p> <p>Review of resident 16's 8/24/16 care plan revealed him to be at risk for pressure ulcers but had not mentioned the current one.</p> <p>Interview on 8/31/16 at 8:25 a.m. with licensed practical nurse (LPN) N regarding resident 16 revealed: *She was working on the floor where he lived. *"There's no pressure ulcer that I'm aware of."</p> <p>Interview on 8/31/16 at 8:30 a.m. with the assistant director of nursing (ADON) regarding resident 16's pressure ulcer revealed: *She was also the wound nurse. *She did not think he had a pressure ulcer and thought it was a wound due to "shearing." *That area had been healed as of last Friday. *It had been treated with an antifungal cream.</p>	F 314		

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F 314	<p>Continued From page 13</p> <p>"We don't do Bradens, we assume everyone is at risk [for a pressure ulcer]."</p> <p>Interview on 8/31/16 at 8:50 a.m. with the director of nursing (DON) regarding resident 16 revealed: *She confirmed their policy was to assume everyone was at risk and Braden assessments were not used. -Instead they do a skin assessment on admission and with every quarterly MDS assessment review.</p> <p>Observation of resident 16 on 8/31/16 at 10:15 a.m. revealed him in the dining room during activity time seated in his wheelchair. Interview at 10:20 a.m. with certified nursing assistant O regarding the resident revealed: *She was working with the resident that day. *He had been in his wheelchair all morning. *He had not been repositioned in four hours. *"He refuses to lay down or get out of his wheelchair."</p> <p>Interview on 8/31/16 at 11:50 a.m. with the Minimum Data Set coordinator regarding resident 16 revealed: *For the 8/24/16 MDS skin assessment she had assessed his wound as a stage two pressure ulcer. -She had based it on their wound care manual and the photo that had been taken with the 8/14/16 initial assessment. *She had notified the ADON/wound care nurse of her finding as it had differed from the initial assessment .</p> <p>Further review of resident 16's medical records and wound documentation forms provided by the ADON revealed:</p>	F 314		

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F 314	<p>Continued From page 14</p> <p>*The location of the wound was the left lower buttock just above the inner thigh crease.</p> <p>*The initial wound documentation was done by an LPN on a JLC Wound Documentation form on 8/14/16.</p> <p>-She had documented it as other from a choice of pressure or other and had hand written "shearing from brief."</p> <p>-Under the section "Treatment being used" she wrote "follow up with wound care specialist."</p> <p>*In his nurses notes on 8/14/16 she wrote "Shearing noted to left inner thigh/groin from brief. Initial wound photo taken, message left with wound care nurse."</p> <p>Interview on 8/31/16 at 3:00 p.m. with the DON and the ADON/wound care nurse regarding resident 16's pressure ulcer revealed:</p> <p>*They agreed he sometimes refused care.</p> <p>*The ADON did not think his wound was a stage two pressure ulcer nor had she assessed it.</p> <p>*They were unaware an LPN could not be solely responsible for the assessment and treatment of a pressure ulcer.</p> <p>*His physician had not been notified of the pressure ulcer nor had the appropriate treatment been started per their policy.</p> <p>Review of the provider's March 2012 LPN Job Description revealed:</p> <p>*"The [provider name] LPN, under the direct supervision of an RN, supports providers...in provision of patient care: includes recording vital signs, discussing chief health concerns, performing testing, and administering injections; assists with procedures and documentation..."</p> <p>Review of the provider's undated New wound/pressure ulcer/stasis ulcer guidelines</p>	F 314		

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F 314	Continued From page 15 revealed: *"The nurse who initially discovers the wound is responsible to (along with other measures) notify the physician." *Classify the pressure ulcer. *Initiate treatment.	F 314			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to ensure the right medication was given to the right resident for one of five residents (27) observed during one of five medication passes by a licensed nurse (K). Findings include: 1. Observation and interview on 8/30/16 at 8:10 a.m. of licensed practical nurse (LPN) K during the medication pass revealed: *She prepared medications for resident 29 who was in the dining room for breakfast. -The resident was scheduled to receive nine medications. *She took the medications in a medication cup to the table where the resident sat next to her husband, resident 27. *She spooned part of the pills out and promptly gave them to resident 27 into his mouth with the spoon. -He swallowed the pills without hesitation. *Both the LPN and the surveyor immediately	F 333	There is no corrective action to be taken for resident #27. All residents could potentially be affected by this deficiency. A medication pass audit was completed with Nurse K on 9/13/16. Other nursing staff responsible for medication administration were also re-educated on 9/20/16 and 9/22/16. The Quality Assurance Nurse will complete medication pass audits 3 times weekly until an audit has been completed on each staff member responsible for passing medications. Results of these audits will be reported by the Director of Nursing at monthly QAPI Committee meetings for review and recommendation.	10/13/16	

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F 333	<p>Continued From page 16</p> <p>realized her error in giving some of resident 29's pills to her husband, resident 27, instead of to resident 29 before this surveyor could stop her. *She took the rest of the pills back to the medication cart to determine which medications had been given to resident 27 instead of to resident 29.</p> <p>Further interview of LPN K and review of resident 29's medication administration record revealed: *The medications given to resident 27 were Tylenol 500 milligrams (mg) and Omeprazol 20 mg. *She stated she was flustered by my presence and had never made an error before. She appeared upset. *She then continued to follow proper procedure after the error had been made by reporting it to the director of nursing (DON) and the physician.</p> <p>Review of resident 27's medical records revealed: *He was admitted on 8/6/15. *His diagnoses included hypertension and dementia. *His Brief Interview for Mental Status assessment score was 13, which showed his cognition was intact. *He had no known allergies to medications. *He was on Tylenol as needed but was not on Omeprazol. -The potential side effects from Omeprazol included possible allergic reaction, headache, and gastrointestinal upset.</p> <p>Interview on 8/31/16 at 3:00 p.m. with the DON regarding resident 27 revealed she agreed he had been given the wrong medication.</p> <p>Review of the provider's revised December 2015</p>	F 333			

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F 333	Continued From page 17 Medication Administration policy revealed: **"The drug, dosage, route, and time for administration should be checked against the MAR [medication administration record] and medication container to verify." **"Confirm resident's identity."	F 333		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on interview and policy review, the provider failed to ensure bedtime snacks were offered to all residents on oral diets. Findings include: 1. Interview on 8/30/16 at 9:30 a.m. with Resident Council members revealed not all	F 368	Resident #28 is being offered bedtime snacks. All residents could potentially be affected by this deficiency. Bedtime snacks will be verbally offered to all residents. A directed in-service training was provided on 9/20/16 and 9/22/16 to all staff responsible for verbally offering bedtime snacks to all residents. <i>*CS/SDDOT/EL</i> <i>*The Registered Dietitian</i> _____ or her designee, will audit residents on 1 nursing unit weekly to ensure that bedtime snacks have been verbally offered to all residents. Audits will be conducted weekly for 4 weeks, and then monthly for 3 months. Results of the audits will be reported by the Registered Dietitian at monthly QAPI Committee meetings for review and recommendation.	10/13/16

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F 368	<p>Continued From page 18</p> <p>residents were offered a snack in the evening before they went to bed. One unidentified resident said she had not been offered a snack for a long time.</p> <p>Surveyor: 32331</p> <p>Interview on 8/30/16 at 5:05 p.m. and on 8/31/16 at 9:30 a.m. with resident 28 in her room revealed:</p> <ul style="list-style-type: none"> *She was not being offered a bedtime snack. *She would like to have been offered a bedtime snack. *There was a snack cart that passed by her room each evening. *Staff had not stopped and offered her and her roommate a bedtime snack. <p>Interview on 8/31/16 at 9:00 a.m. with the registered dietitian (RD) and dietary managers C and D regarding the residents being offered a bedtime snack revealed:</p> <ul style="list-style-type: none"> *The bedtime snacks were delivered by 7:00 p.m. each evening by the dietary department. *Each of those snack carts were placed at the nurses station on each unit. *Residents with a scheduled bedtime snack had stickers attached to the food item. *Those carts contained a variety of foods including: <ul style="list-style-type: none"> -Sandwiches. -Ice cream. -Yogurt. -Fruit and juices. -Milk. -Bagged snacks such as crackers and cookies. -Nuts. -Decaffeinated coffee. *Foods that had needed refrigeration were placed in each unit's refrigerator. *The nursing department was responsible for 	F 368		

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F 368	<p>Continued From page 19 offering the snacks to the residents at bedtime.</p> <p>Interview on 8/31/16 at 9:55 a.m. with registered nurse E regarding the above revealed: *The bedtime snacks were delivered around 7:00 p.m. each evening by the dietary department. *The nursing department was responsible for offering the bedtime snacks. *Residents with a scheduled bedtime snack had stickers attached to the food item. -Those residents snacks were offered and documented. *Residents not on scheduled snacks were not being documented as having been offered.</p> <p>Interview on 8/31/16 at 10:00 a.m. with certified nursing assistant (CNA) F regarding the above revealed: *Residents on a scheduled bedtime snack were listed in the CNA Flow Sheet-PM Shift form. -Those residents snacks were offered and documented on that sheet. *Residents not on scheduled snacks were not being documented as having been offered a snack on that sheet.</p> <p>Interview on 8/31/16 at 11:05 a.m. with the director of nursing regarding the above revealed: *Her expectation was all residents on oral diets were to have been offered a bedtime snack. *The dietary department was responsible for preparing the bedtime snacks. *The nursing department was responsible for offering the bedtime snacks.</p> <p>Interview on 8/31/16 at 11:10 a.m. with the registered dietitian (RD) regarding the above confirmed: *Her expectation was all residents on oral diets</p>	F 368		

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F 368	<p>Continued From page 20</p> <p>were to have been offered a bedtime snack. *Residents with a scheduled bedtime snack were offered and documented on the medication administration record (MAR) or on the CNA flow sheet. *Residents not on scheduled snacks were not being documented as having been offered a snack.</p> <p>Interview on 8/31/16 at 2:35 p.m. with licensed practical nurse G regarding the residents being offered a bedtime snack revealed: *Bedtime snacks were distributed to residents from 7:30 p.m. through 7:45 p.m. *Residents on a scheduled bedtime snack were documented on: -The MAR or on the: -CNA flow sheet. *Residents not on scheduled snacks were not being documented as having been offered a snack.</p> <p>Interview on 8/31/16 at 2:40 p.m. with CNA H regarding the above revealed: *Bedtime snacks were distributed to residents by nursing staff. *Residents with a scheduled bedtime snack had stickers attached to the food item. -Those residents snacks were offered and documented. *The rest of the snacks were "up for grabs." *Residents not on scheduled snacks were not being documented as having been offered a snack.</p> <p>Review of the provider's undated Snacks policy revealed: *The dietary staff prepared nourishments for the bedtime snack cart.</p>	F 368			

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F 368	Continued From page 21 *Planned nourishments were delivered to each nursing unit at approximately 7:00 p.m. *A bedtime snack was available for all residents. *The nursing staff distributed the snacks. *The snack should have been documented in the MAR or CNA flow sheet to track intake.	F 368		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	Housekeepers A & B were re-educated on 9/20/16 regarding the manufacturer's instructions for the proper contact time for 3M Non-Acid Disinfectant Bathroom Cleaner. All residents could potentially be affected by this deficiency. Environmental Services staff was re-educated at a directed in-service on 9/21/16 regarding the need to follow manufacturer's instructions for products intended for surface disinfection. The Environmental Services Director, or his designee, will conduct audits of cleaning procedures weekly for 4 weeks, and then monthly for 3 months. Results of the audits will be reported by Environmental Services Director at monthly QAPI Committee meetings for review and recommendation.	10/13/16

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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
F 441	<p>Continued From page 22</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625</p> <p>Surveyor: 37545 Based on observation, interview, policy review, and manufacturer's instruction review, the provider failed to follow the correct procedure for disinfection contact time for 3M Non-Acid Disinfectant Bathroom Cleaner by two of two observed housekeeping staff (A and B). Findings include:</p> <p>1. Observation on 8/30/16 at 8:25 a.m. of housekeeper A while cleaning a resident's bathroom revealed she: *Sprayed the chemical 3M Non-Acid Disinfectant Bathroom Cleaner on on the top of the sink and on the toilet bowl seat. *Immediately wiped both surfaces with a cloth.</p> <p>Interview immediately following the above observation with housekeeper A revealed: *That it was part of her normal cleaning routine. *She was not aware of the ten minute contact time for proper disinfection.</p> <p>Observation on 8/31/16 at 8:28 a.m. of housekeeper B while cleaning a resident's bathroom revealed she: *Sprayed the chemical 3M Non-Acid Disinfectant</p>	F 441		

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F 441	<p>Continued From page 23</p> <p>Bathroom Cleaner on the top of the sink and on the toilet bowl seat. *Immediately wiped both surfaces with a cloth.</p> <p>Interview immediately following the above observation with housekeeper B revealed: *That it was part of her normal cleaning routine. *She was not aware of the ten minute contact time for proper disinfection. *She stated "This is how I was trained."</p> <p>Interview on 8/30/16 at 2:05 p.m. with the infection control nurse revealed it was her expectation the housekeeping staff would follow the manufacturer's instructions for contact time regarding the above cleaner.</p> <p>Interview on 8/31/16 at 3:00 p.m. with the environmental services supervisor revealed: *It was his expectation the housekeeping staff follow the manufacture instructions for contact time on the 3M Non-Acid Disinfectant Bathroom Cleaner. *The contact times with environmental staff was reviewed at quarterly meetings.</p> <p>Review of the 2010 Infection Control Environmental Services/Laundry policy revealed no information regarding the contact time for disinfection when using the 3M Non-Acid Disinfectant Bathroom Cleaner.</p> <p>Manufacturer's instructions for the 3M Non-Acid Disinfectant Bathroom Cleaner spray contact time revealed the product must sit for ten minutes to disinfect a surface.</p>	F 441			

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/31/16. 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 9/1/16 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 K033, K045, and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure one of three exit enclosures out of building 01 maintained a fire rating of at least one hour. Findings include: 1. Observation at 1:15 p.m. on 8/31/16 revealed a	K 033	The latching hardware has been replaced on the exit door identified in the findings. All doors in the facility could be affected by the findings for this deficiency. All doors will continue to be checked on a monthly basis to ensure that they are latching properly. The Environmental Services Director will conduct audits on exit doors monthly for a period of 3 months. Results of the audits will be reported by The Environmental Services Director at monthly QAPI Committee meetings for review and recommendation.	9/1/16

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

John W. Dillman

TITLE

Pres/CEO

(X6) DATE

9-23-16

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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K 033	Continued From page 1 door to south stairwell enclosure on the second floor near the separation wall between building 01 and building 02. Testing of that door at that time revealed the latching hardware would stick into the door frame and would not engage the door frame. Interview with the director of maintenance at the time of the observation and testing revealed he had just checked those stairwell doors. He was unsure why that latching hardware was not working. He indicated those doors were checked on a monthly basis.	K 033		
K 034 SS=C	This deficiency has the potential to affect one of three stairwell enclosures. NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 32334 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: 1. Observation at 10:50 a.m. on 8/30/16 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. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency	K 034		F

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K 034	Continued From page 2 identified in K000.	K 034		
K 045 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on observation and interview, the provider failed to ensure the means of egress was properly illuminated in one randomly observed location (third floor west stairwell). Findings include:</p> <p>1. Observation at 2:45 p.m. on 8/31/16 revealed a stair enclosure on the west end of the third floor resident wing. That stairwell enclosure was dark upon observation and did not provide adequate illumination of the exit discharge means of egress. A light fixture was provided in that stairwell but was not illuminated.</p> <p>Interview with the director of maintenance at the time of the above observation confirmed that condition. He indicated the fixture must have had a light bulb that was not working. He indicated exit discharge lighting was checked on a monthly basis. He stated that light must have been missed or not working the last time it was checked.</p> <p>This deficiency has the potential to affect one of six smoke compartments and one of three stairwells.</p>	K 045	<p>The light fixtures in the identified stair enclosure have been replaced with fixtures featuring LED lighting for better illumination.</p> <p>All light fixtures adjacent to a means of egress from the building could potentially be affected by the findings in this deficiency.</p> <p>Maintenance personnel will continue to check Exit door lighting on a monthly basis. The Environmental Services Director will conduct monthly audits for a period of 3 months to ensure that there is adequate lighting in all Exit door areas. Results of the audits will be reported by the Environmental Services Director at monthly QAPI Committee meetings for review and recommendation.</p>	9/16/16
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062	SEE NEXT PAGE	

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K 062 SS=D	Continued From page 3 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review, observation, and interview, the provider failed to ensure the sprinkler system was provided with proper testing and maintenance in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The required 3 month (quarterly) testing of the sprinkler system waterflow sensing devices was not being conducted. Findings include: 1. Document review and interview at 9:30 a.m. on 8/31/16 revealed the director of maintenance was unable to provide documentation of the required quarterly testing of the waterflow sensing devices on the fire sprinkler system. He indicated he had conducted the quarterly flow tests but could not find the dates on when they had been tested. 2. Observation at 10:50 a.m. on 8/31/16 revealed a fire sprinkler riser in the basement of the original 1958 building (building 01). Interview with the director of maintenance at the time of the above observation when questioned on how he was conducting the quarterly flow test revealed he was testing the flow switch from an improper test valve. He indicated he would open up the valve to the main drain that provided flow through a 2" drain line to the exterior. Quarterly flow testing should have been done through an inspectors test valve that provided flow through a drain sized to simulate a flow similar to a fire	K 062	Maintenance staff will test and document all sprinkler system waterflow sensing devices on a quarterly basis. They will also be tested annually by the contractor that conducts an annual inspection of the sprinkler system. An appropriately-sized test port will be installed in the area identified in finding #2 so that the quarterly flow test can be conducted. A plumber will be consulted to reconfigure the flow switch identified in finding #3 so that it can be flow tested. This finding affects the facility's entire sprinkler system. The Environmental Services Director will conduct ongoing audits to ensure that quarterly testing of the sprinkler system waterflow sensing devices is being done and documented. Results of the audits will be reported by the Environmental Services Director at monthly QAPI Committee meetings for review and recommendation.	10/13/16

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K 062	<p>Continued From page 4 sprinkler head orifice.</p> <p>3. Observation at 11:35 a.m. on 8/31/16 revealed a flow switch in the maintenance shop in the basement of the 1968 addition (building 02). Interview with the director of maintenance at the time of the above observation revealed he was unaware of how to test that particular flow switch. He indicated he did not test all the flow switches in the building, just the ones located at the main sprinkler risers. All water flow sensing switches should have been tested on a quarterly basis.</p> <p>This deficiency has the potential to affect all building occupants and all smoke compartments.</p>	K 062		

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/31/16. Jenkins Living Center (Building 02) 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 9/1/16 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 K045 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 9/28/16 per telephone with facility administrator, L F/SDDO/HJEL	
K 034 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to ensure two of two stairs (east and west stairs) conformed with required means of egress stairway dimensional criteria. Findings include: 1. Observation at 10:55 a.m. on 8/30/16 revealed the door swinging into the second floor west stair enclosure reduced the landing to twenty-one	K 034		F

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

Forth M. Williams

TITLE

Pres CEO

(X6) DATE

9-23-16

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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K 034	Continued From page 1 inches. Observation at 11:45 a.m. on 8/30/16 also revealed the door swinging into the second floor east stair enclosure reduced the landing to eleven inches. Document review of previous survey data confirmed the condition.	K 034			
K 045 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 Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the means of egress was properly illuminated in one randomly observed location (first floor west stairwell). Findings include: 1. Observation at 10:45 a.m. on 8/31/16 revealed a stair enclosure on the west end of the first floor. Exit discharge out of that stairwell enclosure revealed no lighting fixture was available to provide proper illumination of that means of egress from the building. Lighting fixtures were available in other locations near the exit discharge but would not be capable of providing the minimum lighting required for the exit discharge. Interview with the director of maintenance at the	K 045	Maintenance staff installed two exterior light fixtures in the area identified in the finding for this deficiency. All light fixtures adjacent to a means of egress from the building could potentially be affected by the findings in this deficiency. Maintenance personnel will continue to check Exit door lighting on a monthly basis. The Environmental Services Director will conduct monthly audits for a period of 3 months to ensure that there is adequate lighting in all Exit door area. Results of the audits will be reported by the Environmental Services Director at monthly QAPI Committee meetings for review and recommendation.	9/16/16	

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K 045	Continued From page 2 time of the above observation confirmed that condition. He indicated he was not aware a light fixture should have been provided at that exit discharge area.	K 045	<p style="text-align: right;">→ *LF/SDDO/H/E L</p> <p>Maintenance staff will test and Document all sprinkler system water flow sensing devices on a quarterly basis. They will also be tested annually by the contractor that conducts an annual inspection of the sprinkler system. An appropriately-sized test port will be installed in the area identified In finding #2 so that the quarterly flow test can be conducted. A plumber will be consulted to reconfigure the flow switch identified in finding #3 so that it can be flow tested. This finding affects the facilities entire sprinkler system. The Environmental Services Director will conduct ongoing audits to ensure that quarterly testing of the sprinkler system water flow sensing devices is being done and documented. Results of the audits will be reported by the Environmental Services Director at monthly QAPI Committee meetings for review and Recommendation.</p>	10/13/16
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on document review, observation, and interview, the provider failed to ensure the sprinkler system was provided with proper testing and maintenance in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The required 3 month (quarterly) testing of the sprinkler system waterflow sensing devices was not being conducted. Findings include:</p> <p>1. Document review and interview at 9:30 a.m. on 8/31/16 revealed the director of maintenance was unable to provide documentation of the required quarterly testing of the waterflow sensing devices on the fire sprinkler system. He indicated he had conducted the quarterly flow tests but could not find the dates on when they had been tested.</p> <p>2. Observation at 10:50 a.m. on 8/31/16 revealed a fire sprinkler riser in the basement of the original 1958 building (building 01). Interview with</p>	K 062		

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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 062	<p>Continued From page 3</p> <p>the director of maintenance at the time of the above observation when questioned on how he was conducting the quarterly flow test revealed he was testing the flow switch from an improper test valve. He indicated he would open up the valve to the main drain that provided flow through a 2" drain line to the exterior. Quarterly flow testing should have been done through an inspectors test valve that provided flow through a drain sized to simulate a flow similar to a fire sprinkler head orifice.</p> <p>3. Observation at 11:35 a.m. on 8/31/16 revealed a flow switch in the maintenance shop in the basement of the 1968 addition (building 02). Interview with the director of maintenance at the time of the above observation revealed he was unaware of how to test that particular flow switch. He indicated he did not test all the flow switches in the building, just the ones located at the main sprinkler risers. All water flow sensing switches should have been tested on a quarterly basis.</p> <p>This deficiency has the potential to affect all building occupants and all smoke compartments.</p>	K 062			

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

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PRINTED: 09/14/2016
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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 08/31/2016
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><i>*Addendums noted with an asterisk per 9/28/16 per telephone with facility administrator. LFISD/DHIEL</i></p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/31/16. Jenkins Living Center (Building 03) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000	<p><i>*LFISD/DHIEL</i></p> <p>Maintenance staff will test and Document all sprinkler system water flow sensing devices on a quarterly basis. They will also be tested annually by the contractor that conducts an annual inspection of the sprinkler system. An appropriately-sized test port will be installed in the area identified</p>	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review, observation, and interview, the provider failed to ensure the sprinkler system was provided with proper testing and maintenance in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The required 3 month (quarterly) testing of the sprinkler system waterflow sensing devices was not being conducted. Findings include:</p> <p>1. Document review and interview at 9:30 a.m. on 8/31/16 revealed the director of maintenance was unable to provide documentation of the required quarterly testing of the waterflow sensing devices</p>	K 062	<p>In finding #2 so that the quarterly flow test can be conducted. A plumber will be consulted to reconfigure the flow switch identified in finding #3 so that it can be flow tested. This finding affects the facilities entire sprinkler system. The Environmental Services Director will conduct ongoing audits to ensure that quarterly testing of the sprinkler system water flow sensing devices is being done and documented. Results of the audits will be reported by the Environmental Services Director at monthly QAPI Committee meetings for review and Recommendation.</p>	10/13/16

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

Forth W. Wilkerson

TITLE

Pres/CEO

(X6) DATE

9-23-16

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.

SEP 28 2016

SD DOH LSC

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

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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 08/31/2016
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 062	<p>Continued From page 1</p> <p>on the fire sprinkler system. He indicated he had conducted the quarterly flow tests but could not find the dates on when they had been tested.</p> <p>2. Observation at 10:50 a.m. on 8/31/16 revealed a fire sprinkler riser in the basement of the original 1958 building (building 01). Interview with the director of maintenance at the time of the above observation when questioned on how he was conducting the quarterly flow test revealed he was testing the flow switch from an improper test valve. He indicated he would open up the valve to the main drain that provided flow through a 2" drain line to the exterior. Quarterly flow testing should have been done through an inspectors test valve that provided flow through a drain sized to simulate a flow similar to a fire sprinkler head orifice.</p> <p>3. Observation at 11:35 a.m. on 8/31/16 revealed a flow switch in the maintenance shop in the basement of the 1968 addition (building 02). Interview with the director of maintenance at the time of the above observation revealed he was unaware of how to test that particular flow switch. He indicated he did not test all the flow switches in the building, just the ones located at the main sprinkler risers. All water flow sensing switches should have been tested on a quarterly basis.</p> <p>This deficiency has the potential to affect all building occupants and all smoke compartments.</p>	K 062		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 04 B. WING _____	(X3) DATE SURVEY COMPLETED 08/31/2016
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: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/31/16. Jenkins Living Center (building 04) was found 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 the deficiency identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 9/28/16 per telephone with facility administrator. LF/SDDO/HJ/EL	
K 034 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to ensure two of two stairs (east and west stairs) conformed with required means of egress stairway dimensional criteria. Findings include: 1. Observation at 11:30 a.m. on 8/31/16 revealed the door swinging into the second floor west and east stair enclosures reduced the landing from between sixteen and seventeen inches respectively. Record review of previous survey data confirmed those conditions. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency	K 034		F

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

John A. Williams

TITLE

ARCS/CEO

(X6) DATE

9-23-16

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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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 identified in K000.	K 034		
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on document review, observation, and interview, the provider failed to ensure the sprinkler system was provided with proper testing and maintenance in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The required 3 month (quarterly) testing of the sprinkler system waterflow sensing devices was not being conducted. Findings include:</p> <p>1. Document review and interview at 9:30 a.m. on 8/31/16 revealed the director of maintenance was unable to provide documentation of the required quarterly testing of the waterflow sensing devices on the fire sprinkler system. He indicated he had conducted the quarterly flow tests but could not find the dates on when they had been tested.</p> <p>2. Observation at 10:50 a.m. on 8/31/16 revealed a fire sprinkler riser in the basement of the original 1958 building (building 01). Interview with the director of maintenance at the time of the above observation when questioned on how he was conducting the quarterly flow test revealed he was testing the flow switch from an improper test valve. He indicated he would open up the valve to the main drain that provided flow through a 2" drain line to the exterior. Quarterly flow</p>	K 062	<p>Maintenance staff will test and Document all sprinkler system water flow sensing devices on a quarterly basis. They will also be tested annually by the contractor that conducts an annual inspection of the sprinkler system. An appropriately-sized test port will be installed in the area identified In finding #2 so that the quarterly flow test can be conducted. A plumber will be consulted to reconfigure the flow switch identified in finding #3 so that it can be flow tested. This finding affects the facilities entire sprinkler system. The Environmental Services Director will conduct ongoing audits to ensure that quarterly testing of the sprinkler system water flow sensing devices is being done and documented. Results of the audits will be reported by the Environmental Services Director at monthly QAPI Committee meetings for review and Recommendation.</p> <p><i>*LF/SDDOH/EL</i></p>	10/13/16

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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 062	<p>Continued From page 2</p> <p>testing should have been done through an inspectors test valve that provided flow through a drain sized to simulate a flow similar to a fire sprinkler head orifice.</p> <p>3. Observation at 11:35 a.m. on 8/31/16 revealed a flow switch in the maintenance shop in the basement of the 1968 addition (building 02). Interview with the director of maintenance at the time of the above observation revealed he was unaware of how to test that particular flow switch. He indicated he did not test all the flow switches in the building, just the ones located at the main sprinkler risers. All water flow sensing switches should have been tested on a quarterly basis.</p> <p>This deficiency has the potential to affect all building occupants and all smoke compartments.</p>	K 062			

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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 08/31/2016
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><i>*Addendums noted with an asterisk per 9/28/16 per telephone with facility administrator.</i></p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code(LSC) (2000 new health care occupancy) was conducted on 8/31/16. Jenkins Living Center (building 05) 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 upon correction of the deficiency identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p><i>*LF/SDDOH/EL</i></p>	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review, observation, and interview, the provider failed to ensure the sprinkler system was provided with proper testing and maintenance in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The required 3 month (quarterly) testing of the sprinkler system waterflow sensing devices was not being conducted. Findings include:</p> <p>1. Document review and interview at 9:30 a.m. on 8/31/16 revealed the director of maintenance was unable to provide documentation of the required quarterly testing of the waterflow sensing devices on the fire sprinkler system. He indicated he had</p>	K 062	<p>Maintenance staff will test and Document all sprinkler system water flow sensing devices on a quarterly basis. They will also be tested annually by the contractor that conducts an annual inspection of the sprinkler system. An appropriately-sized test port will be installed in the area identified in finding #2 so that the quarterly flow test can be conducted. A plumber will be consulted to reconfigure the flow switch identified in finding #3 so that it can be flow tested. This finding affects the facilities entire sprinkler system. The Environmental Services Director will conduct ongoing audits to ensure that quarterly testing of the sprinkler system water flow sensing devices is being done and documented. Results of the audits will be reported by the Environmental Services Director at monthly QAPI Committee meetings for review and Recommendation.</p>	10/13/16

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

[Signature]

TITLE

MRS CEO

(X6) DATE

9-23-16

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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 08/31/2016
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 062	<p>Continued From page 1</p> <p>conducted the quarterly flow tests but could not find the dates on when they had been tested.</p> <p>2. Observation at 10:50 a.m. on 8/31/16 revealed a fire sprinkler riser in the basement of the original 1958 building (building 01). Interview with the director of maintenance at the time of the above observation when questioned on how he was conducting the quarterly flow test revealed he was testing the flow switch from an improper test valve. He indicated he would open up the valve to the main drain that provided flow through a 2" drain line to the exterior. Quarterly flow testing should have been done through an inspectors test valve that provided flow through a drain sized to simulate a flow similar to a fire sprinkler head orifice.</p> <p>3. Observation at 11:35 a.m. on 8/31/16 revealed a flow switch in the maintenance shop in the basement of the 1968 addition (building 02). Interview with the director of maintenance at the time of the above observation revealed he was unaware of how to test that particular flow switch. He indicated he did not test all the flow switches in the building, just the ones located at the main sprinkler risers. All water flow sensing switches should have been tested on a quarterly basis.</p> <p>This deficiency has the potential to affect all building occupants and all smoke compartments.</p>	K 062		

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FORM APPROVED

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 08/31/2016
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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	<p>Compliance/Noncompliance Statement</p> <p>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/29/16 through 8/31/16. Jenkins Living Center was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

For M. Williams

TITLE

Pres/CEO

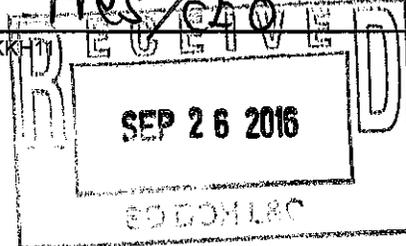
(X6) DATE

9-23-16

STATE FORM

6899

KKK-11



If continuation sheet 1 of 1