STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 SOUTH MAPLE STREET , WATERTOWN, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/19/26 through 5/21/26. Jenkins Living Center was found not in compliance with the following requirements: F684, F761, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/19/21 through 5/21/26. The area surveyed was regarding resident elopement. Jenkins Living Center was found in compliance.	F0000		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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.	F0761	1. Upon identification of the deficient practice, the medication carts involved were immediately secured. Licensed nursing staff involved in the observations were counseled and re-educated regarding facility expectations and the Medication Administration Policy requiring medication carts to remain locked whenever not under the direct supervision of the licensed nurse administering medications. A facility-wide inspection of all medication carts was completed on May 21, 2026, to verify that carts were functioning properly and capable of being secured. No concerns were identified. No residents were noted to have experienced negative outcomes related to the deficient practice. 2.All residents receiving medications from facility medication carts have the potential to be affected by the deficient practice. The Director of Nursing (DON), ADON, Unit Managers, and Nursing Supervisors completed observations of medication administration practices on all nursing units to verify compliance with medication cart security requirements. Any identified concerns were addressed immediately through staff coaching and education.	06/12/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kasey Klapperich	President / CEO	6/12/2026

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F0761 SS = E	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure that resident medications were secured by three of three licensed nurses, contracted travel licensed practical nurse (LPN) I, LPN M, and registered nurse (RN) nurse manager H, who left medication carts unlocked and unattended. Findings include. 1. Observation on 5/19/26 at 11:01 a.m. revealed registered nurse (RN) nurse manager H left the medication cart unlocked, in the nurse's station by the elevator and storage room marked room 311, during the fire drill. 2. Observation and interview on 5/20/26 at 8:19 a.m. outside of resident 9's room with contracted travel LPN I revealed there was a medication cart that was unlocked and no staff member was present. At 8:20 a.m., contracted travel LPN I returned to the medication cart and confirmed it was unlocked. She left the cart unlocked and went into the dining room to give a resident their medication. She stated that it was not her normal practice to leave the medication cart unlocked, had forgotten to lock it, and was away from it for a few minutes. 3. Observation on 5/20/26 at 8:53 a.m. revealed LPN I left the medication cart unlocked, in the nurse's station by the elevator and storage room marked room 311, until 9:10 a.m. when she returned to the cart. 4. Observation on 5/20/26 at 11:02 a.m. revealed LPN I left the medication cart unlocked, in the nurse's station by the elevator and storage room marked room 311. LPN I then returned to the medication cart at 11:04 a.m. 5. Interview on 5/20/26 at 2:43 p.m. with LPN I revealed she knew she had left the medication cart unlocked and that it should be locked when she walked away from it. 6. Observation on 5/20/26 at 6:58 p.m. in the oak center unit revealed the medication cart was unlocked and unattended by any staff. There was two unidentified certified nursing assistants (CNAs) who walked past the medication cart during the observation. There were also four unidentified residents sitting four feet away from the medication	F0761	3.The facility reviewed and reinforced its Medication Administration Policy with all licensed nursing staff, including facility-employed and agency nursing personnel. Education was provided to all licensed nurses regarding: • Medication carts must remain locked whenever unattended. • Medication carts must remain secured during emergencies, including fire drills. • Medication carts may only remain unlocked when under the direct observation and control of the licensed nurse administering medications. • Nurses are responsible for maintaining possession of medication cart keys at all times. Education is provided to nursing staff through in-service training on 6/8/26 and 6/9/26 or the Paycom portal platform. Confirmation of completion will be identified through a sign-off sheet from the in-service or the attestation staff signing in the Paycom Portal. Agency nursing personnel will receive education on medication cart security requirements during orientation and prior to independently administering medications. 4.The DON, ADON, Unit Managers, or designee will conduct medication cart security audits as follows: • Two audits per week for 3 weeks. • Weekly observations for two additional weeks. Any identified concerns will result in re-education. Audit results will be reviewed through the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. The QAPI Committee will determine if additional monitoring or interventions are necessary to ensure sustained compliance. Responsible Person: Director of Nursing, ADON, Unit Managers, and Administrator	

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F0761 SS = E	Continued from page 2 cart in the television area. 7. Interview on 5/20/26 at 7:03 p.m. with LPN M revealed she had worked for the facility since December of 2025. She was the nurse in charge of the oak center unit for her scheduled shift which started at 6:00 p.m. She had just come from a resident's room and she confirmed the medication cart was left unlocked and that she had the medication cart keys. She acknowledged that the medication cart should always be locked when unattended. 8. Interview on 5/20/26 at 7:10 p.m. with RN G revealed she expected the medication cart to be locked whenever it was not attended by the nurse. 9. Review of the provider's revised July 2025 Medication Administration policy revealed "15. The medication cart should always be locked unless it is in direct view of the nurse/UAP [unlicensed assisted personnel] "	F0761		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	1.Upon identification of the deficient practice corrective action was taken. Resident 44's care practices were reviewed with the involved staff members. Resident 6's catheter care and infection control practices were reviewed with the involved staff. Resident 2's catheter care observation was reviewed with the involved registered nurse. No adverse outcomes related to the identified deficient practices were noted. All mechanical lifts identified during survey observations were cleaned and disinfected. Mechanical lifts identified with damaged or uncleanable surfaces were repaired. Missing safety clips and damaged surfaces were reported to maintenance and corrected or replaced as appropriate. 2.The Director of Nursing, ADON, Unit Managers, or designee conducted facility-wide observations of: · Hand hygiene practices · Glove use and glove changes between tasks · Enhanced Barrier Precaution compliance · Foley catheter care procedures · Cleaning and disinfection of shared resident care equipment · Mechanical lift condition and cleanliness Any identified concerns were corrected through staff coaching and re-education.	6/12/2026

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F0880 SS = E	Continued from page 3 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: A. Based on observation, interview, and policy review, the provider failed to ensure infection control practices were followed by three of three observed certified nursing assistants (CNA) (D and E) and one of one registered nurse (RN) G when assisting three	F0880	3.Education is provided to nursing staff through in-service training on 6/8/26 and 6/9/26 or the Paycom portal platform. Confirmation of completion will be identified through a sign-off sheet from the in-service or the attestation staff signing in the Paycom Portal. • Standard Precautions • Appropriate hand hygiene practices • Proper glove use and glove changes between tasks • Foley catheter care procedures • Cleaning and disinfection of resident care equipment • Reporting damaged equipment requiring repair or replacement The facility reviewed and reinforced the Infection Prevention and Control Program, Glove Technique Policy, Standard Precautions Policy, Foley Catheter Management Policy, and Cleaning and Disinfection of Equipment Policy. All mechanical lifts were inspected to ensure: • Equipment was clean and disinfected • Safety clips were present and functioning • Footboards and surfaces were intact and cleanable • Disinfectant wipes were readily available on units 4.The DON, ADON, Unit Managers, or designee will conduct audits as follows: Hand Hygiene / PPE Audits • Two audits per week for 3 weeks. • Weekly observations for two additional weeks. Mechanical Lift Cleaning Audits Two audits per week for 3 weeks. • Weekly observations for two additional weeks. Any identified concerns will be corrected and staff re-educated. Audit findings will be reviewed monthly by the Quality Assurance and Performance Improvement (QAPI) Committee for a minimum of three months. Additional monitoring will be implemented as necessary to ensure sustained compliance. Responsible Persons: Administrator, Director of Nursing, ADON, Unit Managers, Nursing Supervisors, Maintenance Director, and Therapy Director	

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F0880 SS = E	Continued from page 4 of four sampled residents (2, 6, and 44) with personal care. Findings include: 1. Observation on 5/20/26 at 8:45 a.m. of CNA D assisting resident 44 in his room revealed there was a sign on the resident's door that indicated he was on enhanced barrier precautions (EBP) (the implementation of personal protective equipment (PPE) which included the use of gloves, gowns, and masks to prevent the spreading of organisms). All staff had to wear a gown and gloves when assisting the resident. Without washing or sanitizing her hands, CNA D put on a gown and a pair of gloves before entering the resident's room. With those gloved hands, CNA D opened the resident's closet door, gathered clean clothes, and laid them on the resident's bed. She moved the resident's bed and the bedside table to make more room to assist him. She tore a garbage bag off a garbage bag roll that was lying on a dresser, opened it up, and placed it on the bed. She raised the resident's bed higher and removed the blanket covering the resident. She opened the bedside stand and took out a package of wet wipes, opened it, and laid it on the resident's bed. With those same gloved hands, CNA D opened the resident's incontinent brief (an absorbent, disposable undergarment worn to help with urine and bowel leakage), grabbed wet wipes, provided personal care, and assisted the resident to turn onto his left side. She grabbed more wet wipes and cleansed his rectal area and buttocks. She removed a bottle of cream from the bedside stand, opened it, put some on her right gloved hand, and applied it to his rectal area and buttocks. While wearing those same gloves, CNA D put a clean incontinence brief on resident 44 and placed Hoyer lift (device used to assist with transferring from one surface to another) sling underneath him with assistance from RN nurse manager H. CNA D moved the Hoyer lift over to the resident's bed, attached the sling to it and used the Hoyer lift remote to lift resident 44 off his bed an transfer him into his recliner. CNA D removed the sling from the lift, opened the resident's door, and pushed the Hoyer lift into the hallway.	F0880		

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F0880 SS = E	Continued from page 5 CNA D changed the resident's shirt, covered him with a blanket, and moved the bedside table closer to him. CNA D removed and discarded her gloves in a trash can, removed her gown, and washed her hands for the first time. 2. Observation on 5/20/26 at 12:30 p.m. of CNAs D and F with resident 44 in his room revealed that without washing or sanitizing their hands, both CNAs put on a gown and a pair of gloves. Both CNAs D and F moved the Hoyer lift closer to resident 44, repositioned the sling underneath the resident, and attached it to the Hoyer lift. CNA D removed the blanket that was covering the resident. She then used the Hoyer lift remote to lift the resident out of the recliner and assisted CNA F with transferring him onto his bed. After they had completed the transfer, they unhooked the sling from the lift and removed it from underneath the resident by rolling him back and forth in bed. CNA D opened resident 44's bedside stand drawer, took out a package of wet wipes, laid it on his bed covers, opened it, and pulled out several wipes. She tore a garbage bag off a garbage bag roll that was lying on a bedside dresser, opened it, placed it on the bed, and raised the bed higher to assist the resident more easily. With those same gloved hands, both CNAs D and F lowered resident 44's pants to check his incontinent brief. He was incontinent with both urine and bowel. CNA D opened the resident's incontinent brief, removed some wet wipes, cleansed his front area, and then assisted the resident to turn onto his left side. She removed more wet wipes and cleansed his rectal area and buttocks. She retrieved a bottle of cream from the bedside stand, opened it, put some on her gloved right hand, and applied it to his rectal area and buttocks. While wearing the same gloves, CNA D put a clean incontinence brief on resident 44 and assisted CNA F with pulling up his pants, positioning him higher in his bed, covering him with a blanket, and attaching his call light to the side rail on his bed. CNA D moved the intravenous (IV) pole and IV tubing so that it was closer to the resident and his bed, and used the bed remote to adjust its height. She opened the resident's door and pushed the Hoyer lift out into the hallway.	F0880		

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F0880 SS = E	Continued from page 6 CNA D and F removed and discarded their gloves in the trash can, removed their gowns, and washed their hands for the first time. 3. Interview on 5/20/26 at 12:50 p.m. with CNA D regarding the above personal care observations with resident 44 revealed that it was her usual process. After reviewing the observed unsanitary processes with resident 44, she acknowledged that she should have changed her gloves and sanitized her hands when they were dirty. She further acknowledged that her process had the potential to create an infection for the resident. 4. Interview on 5/21/26 at 1:45 p.m. with director of nursing (DON) B regarding the observations of CNA D completing personal care with resident 44 revealed she expected hand hygiene (HH, washing and sanitizing hands) and glove changing to be done between each new task. Tasks included gathering supplies and touching items in the environment, which were dirty. Same with personal/perineal care, gloves should be changed after the completion of that task and sanitizing of hands prior to touching more items in the environment. She acknowledged that CNA D's process created the potential for an infection to occur for resident 44. 5. Observation on 5/21/26 at 11:18 a.m. of CNA E and contracted travel licensed practical nurse (LPN) I providing personal care to resident 6 in her room revealed resident 6 had a sign on his door indicating he was on EBP. CNA E and LPN I used alcohol-based sanitizer, put on a gown and a pair of gloves before entering resident 6's room. CNA E prepared wet washcloths, placed a yellow bag on the bedside table, and put the wet washcloths on top of the yellow bag. Resident 6 had personal items, which included (call light, open Gatorade container, blue water mug, and remote control) on top of his bedside table. Resident 6 was incontinent of bowel and had a urinary catheter (flexible tubing placed in the bladder to drain urine). After CNA E cleaned resident 6's rectal area with the wet washcloths, she put them in the yellow bag with the clean wet washcloths. CNA E placed resident 6's soiled incontinent brief on the bedside table on top of the clean washcloths.	F0880		

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F0880 SS = E	Continued from page 7 CNA E placed a soiled clothing protector that was on the resident's bed from the morning meal service over the yellow bag, as well as over the resident's drinking straw and mug with a drinking straw. With those same gloved hands, she touched the resident's clean incontinent supplies, blankets, the resident's bedside table, and the tops of resident 6's open Gatorade bottle, water mug, bed remote, TV remote, and call light. 6. Interview on 5/20/26 at 11:45 a.m. with CNA E revealed that she did not clean the urinary catheter at all during resident 6'spersonal cares. She would normally clean that but did not do it that time. 7. Interview on 5/20/26 at 2:43 p.m. with contracted travel LPN I revealed that she expected the staff to change their gloves after cleaning the resident before cleaning other items. She expected the urinary catheter tubing to be cleaned during the resident's personal care. 8. Observation on 5/20/26 at 7.21 p.m. of RN G assisting with resident 2's urinary catheter care revealed that RN G put on a pair of gloves from the right-side pocket of her uniform. She removed and discarded those gloves after resident 2's cares were completed. Without washing her hands RN G touched two washcloths and two used alcohol pads that were positioned under the resident's catheter tubing used during the catheter cares and then touched the resident's bedside table. 9. Interview on 5/21/26 at 12.35 p.m. with LPN/infection preventionist (IP) P revealed she expected the staff to change their gloves after providing resident's perineal care and to wash their hands? before doing anything else. She stated, "It is very inappropriate" to touch the resident's personal items or drinking cups with the same gloves used during their perineal care. She would prefer that the dirty linen bags to be placed on the side of the bed, and not on the resident's bedside table. If the bedside table was used during the resident's personal care, there should be no personal items on the table at the same time.(add line space) LPN/IP P expected the staff to not touch, with bare hands, soiled wash cloths, or used alcohol pads before touching additional personal items. She expected hand hygiene to be completed in between tasks. 10. Review of the provider's reviewed June 2023 Infection Prevention and Control Manual Glove Technique (Non-Sterile) policy revealed "Apply clean non-sterile gloves when touching blood, body fluids,	F0880		

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F0880 SS = E	Continued from page 8 secretions, excretions, contaminated items, mucous membranes, and non-intact skin. Don clean gloves between tasks and procedures on the same resident after contact with blood, body fluids, secretions, excretions. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. Perform hand hygiene after the removal of gloves. Key point: Do not carry gloves in the pocket of uniform or lab coat " 11. Review of the provider's reviewed September 2022 Infection Prevention and Control Manual Standard Precautions-Gloves policy revealed "it is the policy of Jenkin's Living Center that gloves will be worn by employees when it is reasonably anticipated that their hands will come in contact with blood, other potentially infectious materials, mucous membranes, non-intact skin, contaminated equipment or surfaces." 12. Review of the provider's reviewed November 2025 Foley Catheter Management policy revealed "10. Clean the catheter tubing a. Hold the catheter securely to avoid pulling. B. Wipe away from the body down the catheter tubing approximately 4-6 inches using smooth strokes. C. Do not tug or place tension on the catheter. 13. Remove gloves and perform hand hygiene." B. Based on observation, interview, and policy review the provider failed to ensure two of two Sara Stedy (non-powered sit-to-stand mechanical lift used to assist from a seated to a standing position) mechanical lift devices, and three of four sit-to-stand (a battery powered mechanical lift used to assist from a seated to a standing position) mechanical lifts were disinfected between resident use. Findings include: 1. Observation on 5/19/26 at 10:25 a.m. revealed a Sara Stedy mechanical lift dated "12-2024" was sitting in east hallway from oak center nursing station had food debris on the foot board, no Sani-wipes (disinfection wipes) were attached to the device. 2. Observation on 5/19/26 at 10:25 a.m. revealed outside resident 2's room there was a sit-to-stand numbered 412020 with food debris on the foot board, and was missing a safety clip on the right side of the latching hook. 3. Observation on 5/19/26 at 10:36 a.m. revealed	F0880		

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JENKIN'S LIVING CENTER	**215 SOUTH MAPLE STREET , WATERTOWN, South Dakota, 57201**

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F0880 SS = E	Continued from page 9 there was a Sara Stedy mechanical lift numbered 25 outside resident 8's room with food debris on the foot board with no disinfectant wipes for cleaning on the machine. 4. Observation on 5/19/26 at 4:10 p.m. revealed there was a Sara Steady mechanical lift in the hallway with torn areas on the black footboard. There was debris in these torn areas, making it an uncleanable surface. 5. Observation on 5/20/26 at 8:43 a.m. revealed there was a sit-to-stand in the hallway numbered 25, which had food debris on the footboard. 6. Observation on 5/20/26 at 9:05 a.m. revealed there was a sit-to-stand numbered 412020 with no clip on the right side of the latching hook and had with food debris and a white powdery substance on the foot board. 7. Observation on 5/20/26 at 9:08 a.m. revealed there was a numbered 25 sit-to-stand mechanical lift sitting outside resident 2's room which had food debris on the foot board and a white colored residue on the black grip pads on the footboard. 8. Observation on 5/20/26 at 9:11 a.m. revealed there was a numbered 19 sit-to-stand mechanical lift missing grip tape on left side of the foot board, and a brownish colored substance on the lower right corner of the foot board. 9. Observation on 5/20/26 at 9:14 a.m. revealed there was a Sara Stedy mechanical lift device in the hallway outside resident 8's room that had a white powder substance on the foot board. There were torn areas on the left and right sides of the black foot board. Food debris was in those torn areas and made it an uncleanable surface. 10. Observation on 5/20/26 at 11:44 a.m. revealed that after observing resident 6's personal cares, CNA E did not clean the sit-to stand used and placed it back into the hallway. 11. Observation on 5/20/26 at 7:06 p.m. revealed there was a Sara Steady mechanical lift dated "5-26" that had a blue creamy substance on the footboard.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = E	Continued from page 10 12. Observation on 5/21/26 at 7:50 a.m. revealed there was a sit-to-stand numbered 412020 with green tape on it numbered 124 in the hallway with food debris on the footboard. 13. Interview on 5/21/26 at 10:17 a.m. with CNA F revealed that mechanical lifts should be cleaned after each resident use. She cleaned any part of the lift that the resident touches. She agreed food debris on the foot boards should be cleaned off as well after a resident used the mechanical lift. 14. Interview on 5/21/26 at 11:22 a.m. with CNA Q revealed she used Sani-wipes to clean the mechanical lifts. When she was done with a mechanical lift transfer for a resident she would clean any surface that the resident touched, so it was ready to use on the next resident. She included the footboard as a space needing to be cleaned. She would notify maintenance by calling them or filling out a maintenance slip on the computer to notify them of needed repairs to the mechanical lifts. 15. Interview on 5/21/26 at 11:30 a.m. with LPN O revealed she expected the mechanical lifts to be sanitized with the Sani cloth wipes between resident use. If something needed to be fixed on the mechanical lifts, she would call for maintenance on the walkie or put in a work order. 16. Interview on 5/21/26 at 11:44 a.m. With contracted travel LPN I revealed she expected the mechanical lifts to be wiped down with the Sani cloths that were available on the lifts or at the nurse's station. If there was something that needed to be fixed, she would use the walkie to call for maintenance or fill out a work order. 17.Interview on 5/21/26 at 12:35 p.m. with LPN/IP P revealed that she expected the mechanical lifts to be wiped down with Sani cloths that were located on the lifts or at the nurse's station. The cleaning should be from top to bottom, including the footboards. The lifts were to be cleaned after each resident use before being placed back into the hallway. Once they were in the hallway, they were considered clean. 18.Interview on 5/21/26 at 2:30 p.m. with DON B revealed she expected the mechanical lifts to be wiped down with the Sani cloths after each use. 19. Review of the provider's reviewed August 2023 Infection Prevention and Control Manual Cleaning	F0880		

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F0880 SS = E	Continued from page 11 and Disinfection of Equipment/Devices policy revealed "7. Reusable equipment will not be used for the care of another resident until it has been appropriately cleaned and disinfected, and single-use items are properly discarded."	F0880		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on the interview, call light log documentation review, and policy review, the provider failed to ensure the staff responded promptly to one of two sampled residents (2) who reported being incontinent (involuntary urine or bowel leakage) while waiting for her call light to be answered. Findings Include: 1. Interview on 5/19/26 at 10:39 am with resident 2 revealed she had concerns that when the facility was short on staff, her call light was not answered quickly enough. She stated, "we wait forever to get the call light answered." This caused her to be incontinent of bowel. She stated, she feels "embarrassed and frustrated when this happens." 2. Resident 2 admitted into the facility on 2/1/2021. Review of resident 2's electronic medical record (EMR) revealed her 4/7/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. She had diagnoses of Hemiplegia (the inability to move or control the muscles) and hemiparesis (one side of a person's body is weak) affecting her left side, contracture (the muscles, tendons or skin becoming tight or stiff and permanently shortened, making it difficult to move a joint) of the left lower leg, and left foot drop (weakness or nerve damage makes it hard to lift the front part of the foot). Resident 2's care plan on 4/13/26 revealed she	F0684	1.Resident 2 was interviewed regarding concerns with call light response times and care needs. The resident's care plan was reviewed to ensure staff were aware of her transfer assistance requirements, continence status, and need for prompt response to toileting requests. Licensed nursing staff and certified nursing assistants assigned to Resident 2 were educated regarding the importance of timely call light response, resident dignity, and compliance with facility call light response expectations. No additional concerns regarding resident care were identified during review. 2.All residents requiring staff assistance for toileting, transfers, activities of daily living, or other care needs have the potential to be affected by delayed call light response times. The Director of Nursing, ADON, Unit Managers, and Nursing Supervisors reviewed call light response reports identifying any possible trends. Times identified for longer call light response times related to early morning get up times, meals and evening times related to residents wanting to go to bed. 3.Education is provided to nursing staff through in-service training on 6/8/26 and 6/9/26 or the Paycom portal platform. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal. • Facility Call Light Response Policy • Resident dignity and quality of care • Communication between staff during busy periods • Escalation process when staff are unable to immediately respond Nursing leadership reinforced facility expectations that staff respond promptly to activated call lights and communicate resident needs to other team members when assistance is delayed. Call light response reports will be reviewed routinely by nursing leadership to identify trends and opportunities for intervention.	6/12/2026

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F0684 SS = D	Continued from page 12 required substantial/maximum assistance from the staff with transfers. Staff were to monitor and document bowel sounds and frequency of bowel movements. Resident 2 was continent of bowel and had a suprapubic catheter (flexible tubing inserted in the lower abdomen placed directly in the bladder to drain urine) in place. 3. Review of resident 2's call light response time report (a summary of resident call-light activity and the staff time responses) from 5/5/26 through 5/20/26 revealed she had eleven call light response times over 20 minutes long and three call light response times over 30 minutes long. 4. Interview on 5/21/26 at 9:02 a.m. with certified nursing assistant (CNA) revealed that she expected the resident's call lights to be answered within to within 5 minutes. 5. Interview on 5/21/26 at 11:30 a.m. with licensed practical nurse (LPN) O revealed the facility's goal was to have call lights answered within 6 minutes, unless the staff were already helping someone else, then the expected call light response time was 15 minutes. 6. Interview on 5/21/26 at 11:44 a.m. with LPN I revealed that she expected the call lights to be answered within 3-5 minutes. 7. Interview on 5/21/26 at 2:30 p.m. with director of nursing (DON) B revealed that she expected the call lights to be answered within 12 to 15 minutes. 8. Review of the provider's undated Call Light Response policy revealed "to ensure residents receive timely assistance, maintain resident safety, uphold resident rights, and support quality care through prompt and appropriate response to all activated call lights. It is the policy of Jenkins Living Center that all resident call lights and assistance alarms will be answered promptly, court	F0684	4.Education is provided to nursing staff through in-service training on 6/8/26 and 6/9/26 or the Paycom portal platform. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal. • Facility Call Light Response Policy • Resident dignity and quality of care • Communication between staff during busy periods • Escalation process when staff are unable to immediately respond Nursing leadership reinforced facility expectations that staff respond promptly to activated call lights and communicate resident needs to other team members when assistance is delayed. Call light response reports will be reviewed routinely by nursing leadership to identify trends and opportunities for intervention. 4. Monitoring and Quality Assurance The Director of Nursing, ADON, Unit Managers, or designee will review call light response reports as follows: • Weekly for four weeks • Bi-weekly for four weeks • Monthly for one month Audits will include: • Number of call lights exceeding facility response expectations or trends • Resident interviews regarding timeliness of assistance • Follow up with staff regarding identified concerns Any identified concerns will result in immediate follow-up, staff coaching, and re-education as indicated. Results of audits will be reviewed through the Quality Assurance and Performance Improvement (QAPI) Committee monthly for a minimum of three months. Additional monitoring will be implemented as necessary to ensure ongoing compliance. Responsible Persons: Administrator, Director of Nursing, ADON, Unit Managers, Nursing Supervisors	
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F0812	1.Upon identification of the deficient practice, dietary staff reviewed dish machine operating procedures and manufacturer temperature requirements. The dish machines were tested to verify proper operation and ability to achieve the required wash and rinse temperatures. Maintenance reviewed the equipment and confirmed proper operation. Dietary staff were re-educated regarding manufacturer instructions, facility policy, and required temperature verification procedures before processing dishes. No resident adverse outcomes related to the deficient practice were identified.	6/12/2026

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F0812 SS = D	Continued from page 13 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, manufacture instruction review, and policy review, the provider failed to ensure that two of three dish machines reached the minimum temperatures for the wash and rinse cycles before washing the dishes. Findings include: 1. Observation and interview on 5/19/26 at 9:32 a.m. in the main kitchen with cook K revealed a sign on the commercial dish machine that read "When taking temps [temperatures] on the dish machines, please make sure you are running the dish machine at least 3 times/or getting to the correct temp before recording a temp as some of them have sat without being ran so they need to get up to temp before using.", signed by food service supervisor L. Cook K ran the first tray of dishes through the dish machine, and the wash temperature reached 142 degrees and the rinse temperature reached 164 degrees. For the second load of dishes that cook K ran through the dish machine the wash temperature reached 154 degrees, and the rinse temperature reached 186 degrees. When asked about the dish machine temperature cook K stated, that she needed to run the dish machine a couple of times to get to the minimum temperature. She confirmed she did not run the dish machine before she started to wash the dishes, and the dish machine did not reach the minimum temperature for the first load. 2. Observation and interview on 5/20/26 at 8:40 a.m. in the second-floor kitchen with cook J revealed cook J ran a tray of dishes through the	F0812	2.All residents receiving meals and food service support have the potential to be affected by improper dish machine sanitization practices. The Dietary Manager and Administrator reviewed dish machine temperature logs and operating procedures for all dietary areas to ensure proper temperature monitoring and compliance with facility policy. All dietary employees utilizing dish machines were assessed for understanding of proper dish machine startup procedures and temperature verification requirements. 3.Education is provided to dietary staff through the Paycom portal platform. Confirmation of completion will be documented through an attestation in the Paycom Portal. • Manufacturer dish machine requirements • Minimum wash temperature of 150°F • Minimum rinse temperature of 180°F • Required startup procedures • Verification of temperatures prior to washing dishes • Documentation requirements • Reporting equipment concerns immediately • Infection control and food safety principles related to dish sanitization The facility revised its monitoring process to require documentation that dish machines have achieved proper temperatures prior to use. Temperature logs will be reviewed routinely by dietary leadership to ensure compliance. Maintenance and dietary departments will communicate regarding any dish machine concerns to ensure prompt corrective action. 4.The Dietary Manager, Administrator, or designee will conduct audits as follows: • Two audits per week for 3 weeks. • Weekly observations for two additional weeks. Audits will include: • Verification of appropriate temperatures • Confirmation temperatures are obtained prior to processing dishes • Review of completed temperature logs • Verification staff are following startup procedures • Follow-up on any identified equipment concerns Any identified concerns will result in corrective action and staff re-education. Audit results will be reviewed through the Quality Assurance and Performance Improvement (QAPI) Committee monthly for a minimum of three months. Additional monitoring will be implemented as necessary to ensure ongoing compliance. Responsible Persons: Dietary Manager, Administrator, Maintenance Director	

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F0812 SS = D	Continued from page 14 dish machine. The wash temperature reached 147 degrees, and the rinse temperature reached 177 degrees. Cook J stated the dish machine temperatures should reach a minimum of 150 degrees for the wash cycle and a minimum of 180 degrees for the rinse cycle. She did not usually run the dish machine, but the facility let an employee go and did not replace them, so now she cooks and helps with the dishes. 3. Interview on 5/20/26 at 8:52 a.m. with food service supervisor L regarding the dish machine temperatures revealed that the staff was educated on how to run the dish machines. The staff knew to run the dish machines a couple of times before running dishes through them, because water sits in the lines and they needed to run them to get the water up to the correct temperatures. There was a sign posted on the dish machine in the main kitchen to remind the staff to run it. She expected the staff to run the dish machines before washing the dishes. 4. interview on 5/21/26 at 10:07 a.m. with maintenance worker N regarding the dish machine temperatures revealed that maintenance was aware there was an issue with the temperatures for the dish machine in the main kitchen. He thought it was fixed when the heating element was replaced in that dish machine. The dietary staff did notify maintenance if there was an issue with kitchen equipment. 5. Interview on 5/21/26 at 12:48 p.m. with administrator A regarding dish machine temperatures revealed that he confirmed the wash temperature needed to be 150 degrees or above and the rinse temperature needed to be 180 degrees or above. He expected the dietary staff to follow the manufacturer's instructions for the dish machines. He agreed the staff should have run the dish machines to get the temperature up before washing dishes. 6. Review of the manufacturer's dish machine instruction revealed the hot water sanitizing wash temperature should be150 degrees Fahrenheit minimum, and a rinse temperature of 180 degrees Fahrenheit minimum. 7. Review of the provider's 2021 Cleaning Dishes/Dish Machine policy revealed "All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing."	F0812		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 5/19/26. Jenkins Living Center was found in compliance.	E0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kasey Klapprodt	President / CEO	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 5/19/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Jenkins Living Center (building 1) was found not in compliance. Please mark an "F" in the completion date column for the K225 deficiency identified as meeting the FSES.	K0000		
K0225 SS = C Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures 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, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and record review, the provider failed to maintain conforming exit stairs for one of three exits (west stair) that deid not have a landing. Findings include: 1 Observation on 5/19/26 at 9:30 a.m. revealed that the west stair connecting the first and second level was not equipped with a landing at the second level. Later review of the previous survey report dated 1/28/25 and communication with the facility administrator on 5/19/26 at 11:41 a.m. confirmed the continued finding. The building meets the FSES. Please mark an "F" in the completion date column.	K0225		F

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas Klapprott	President/CEO	6/12/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

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K0000 Bldg. 02	INITIAL COMMENTS A recertification survey was conducted on 5/19/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Jenkins Living Center (building 2) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards. Please mark an "F" in the completion date column for the K225 deficiency identified as meeting the FSES.	K0000		
K0222 SS = C Bldg. 02	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail	K0222	On 6/8/2026, the required delayed-egress signage was installed on the third-floor west stair enclosure door in Building 2. The signage was placed in accordance with NFPA 101 requirements and verified by the Director of Environmental Services. 2.The Director of Environmental Services conducted an audit of all delayed-egress doors throughout the facility to verify the presence of required signage and compliance with Life Safety Code requirements. No other noncompliance issues were identified. 3.The facility revised its Life Safety inspection process to include verification of required signage on all delayed-egress doors. The Director of Environmental Services and maintenance staff were educated regarding NFPA 101 requirements for delayed-egress locking systems, including required signage. 4.The Director of Environmental Services or designee will complete monthly audits of all delayed-egress doors for three months to verify the presence and condition of required signage. Audit findings will be reviewed through the facility's QAPI process. Any concerns identified will be corrected immediately.	6/8/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas Thayer	President/CEO	6/12/26

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JENKIN'S LIVING CENTER	215 SOUTH MAPLE STREET , WATERTOWN, South Dakota, 57201

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K0222 SS = C Bldg. 02	Continued from page 1 safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation, interview, and testing, the provider failed to maintain exit locked exit doors in accordance with Section 7.2.1.6.1. The magnetically locked door for the third floor of building 2 to the west stair enclosure was not equipped with delayed egress signage. Findings include: 1. Observation on 5/19/26 at 11:07 a.m. revealed a magnetically locked exit door to the west stair	K0222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 SOUTH MAPLE STREET , WATERTOWN, South Dakota, 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
K0222 SS = C Bldg. 02	Continued from page 2 enclosure on the third floor. Interview with the director of environmental services revealed the door's magnet was a delayed egress lock. Testing of the door at the time of the observation with the lock engaged confirmed that the lock was a delayed egress lock. The door was not equipped with delayed egress signage. Interview with the director of environmental services at the time of the observation confirmed that finding.	K0222		
K0225 SS = C Bldg. 02	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures 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, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and record review, the provider failed to maintain a minimum clear space of 22 inches between the swing of the door and the newel post in one of the three stairwells (southwest stair enclosure). Findings include: 1. Observation on 5/19/26 at 10:30 a.m. revealed that the door swinging into the second-floor west stair enclosure reduced the landing to 21 inches. 2. Observation on 5/19/26 at 10:37 a.m. also revealed that the door swinging into the second-floor west stair enclosure reduced the landing to 11 inches. Later review of the previous survey report dated 1/28/25 and communication with the facility administrator on 5/19/26 at 11:44 a.m. confirmed the continued finding. The building meets the FSES. Please mark an "F" in the completion date column.	K0225		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 SOUTH MAPLE STREET , WATERTOWN, South Dakota, 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
K0000 Bldg. 03	INITIAL COMMENTS A recertification survey was conducted on 5/19/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Jenkins Living Center (building 3) was found in compliance.	K0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	President/CEO	6/12/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 SOUTH MAPLE STREET , WATERTOWN, South Dakota, 57201

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K0000 Bldg. 04	INITIAL COMMENTS A recertification survey was conducted on 5/19/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Jenkins Living Center (building 4) was found in compliance.	K0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristy Klapprott	President/CEO	6-12-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 SOUTH MAPLE STREET , WATERTOWN, South Dakota, 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
K0000 Bldg. 05	INITIAL COMMENTS A recertification survey was conducted on 5/19/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Jenkins Living Center (building 5) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0222 SS = C Bldg. 05	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or	K0222	1.On 6/8/26, the magnetic locking devices on the east and west exit doors of Building 5 were removed from service, and the doors were returned to free egress operation. The facility verified that occupants can exit through both doors without the use of a keypad, key, tool, or special knowledge. 2.The Director of Environmental Services conducted an audit of all exit doors throughout the facility to verify compliance with NFPA 101 requirements for egress doors and special locking arrangements. No additional non-compliant locking mechanisms were identified. 3.The facility updated its Life Safety and Environmental Services inspection process to include review of all locking devices on egress doors whenever a unit's function or resident population changes. The Director of Environmental Services and Administrator were educated on NFPA 101 Section 7.2.1.6 requirements regarding special locking arrangements and egress door compliance. 4.The Director of Environmental Services or designee will complete monthly audits of all exit doors for three months to verify proper operation and compliance with Life Safety Code requirements. Audit results will be reported through the facility's Quality Assurance and Performance Improvement (QAPI) process. Any identified concerns will be corrected immediately.	6/8/26

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thaler Thlapper	President/CEO	6-12-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 SOUTH MAPLE STREET , WATERTOWN, South Dakota, 57201

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K0222 SS = C Bldg. 05	Continued from page 1 is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain exit locked exit doors in accordance with Section 7.2.1.6 for the east and west exit doors on the first floor of building 5. Findings include: 1. Observation on 5/19/26 at 11:22 a.m. revealed that the magnetically locked doors for the east and west exits were equipped with keypads to release the magnet locks. 2. Interview on 5/19/26 at 11:25 a.m. with the director of environmental services revealed that the door's magnets were not delayed egress locks. He	K0222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0222 SS = C Bldg. 05	Continued from page 2 stated that the floor had previously been part of a secure wing. The exit door magnetic locks did not meet the requirements of Section 7.2.1.6 Special Locking Arrangements.	K0222		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10703	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 S MAPLE ST 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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on from 5/19/26 through 5/21/26. Jenkins Living Center was found in compliance.	S 000		

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

Kasey Klapprodt | President / CEO | 06/12/2026