STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING _____ B. WING _____	C 06/11/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/10/25 through 6/11/25. Areas surveyed included nursing services related to medication errors, water pass process, and quality of care related to resident falls. Jenkins Living Center was found not in compliance with the following requirement(s): F658.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, and policy review, the provider failed to ensure a contracted licensed practical nurse (LPN) (F) had followed nursing professional standards of practice for the preparation of one of one sampled resident's (1) physician-ordered medication administration delivered through a syringe driver according to the provider's policy. That failure resulted in a medication error. Findings include: 1. Review of 5/13/25 SD DOH FRI revealed: *Resident 1 was admitted on 5/8/25 and was receiving hospice services. *A syringe driver (a battery powered pump that delivers medications under the skin) was initiated on 5/9/25.	F 658	1. The error involving the resident was immediately addressed on 5/12/25. The facility promptly notified the physician and pharmacy. Both parties confirmed that no adverse outcome occurred. 2. No other residents are currently using a syringe at this time from all facility audit conducted on 6/27/2025. 3. The syringe driver policy was reviewed and revised to explicitly state that, as of July 1, 2025, only Prairie Lakes Hospice staff will conduct starting, adjusting, or filling/refilling of the syringe driver. Education was initiated on July 1, 2025, to facilitate the transition of the facility's policies and procedures. All nurses will sign in to the Paycom portal for updated policies and procedures, effective July 7, 2025, to confirm their understanding of the changes.	7/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kasey Klapprodt	President / CEO	7/6/2025

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 658	Continued From page 1 *That pump was to continuously deliver medications for pain, anxiety, and agitation to the resident twenty-four hours a day. *On 5/12/25 at 4:30 a.m., the syringe medication was prepared by travel licensed practical nurse (LPN) F who then began its administration. *The oncoming nurse, LPN D changed the syringe at 6:30 a.m. and identified the controlled (medications at risk for addiction and abuse) medication count for morphine (controlled pain medication) was incorrect. *LPN F was then interviewed by the assistant director of nursing (ADON) (G). -LPN F reported she mixed the resident's ordered medications in the syringe, but she did not add the instructed distilled water to the syringe. *Avera pharmacy and the resident's primary care provider (PCP) were notified of the medication error. -They had no concerns of adverse outcome due to the medication error. 2. Interview on 6/10/25 at 3:15 p.m. with LPN D revealed: *She had been employed at the facility for more than ten years. *She reported using the syringe driver to administer medication to residents on a regular basis. -She reported syringe drivers were commonly used with hospice residents nearing the end of their life. *She was able to show the syringe driver kit (syringe driver and associated supplies that were stored in a plastic bin) and demonstrated its setup and function. *She stated she knew how to prepare the medication for the syringe driver by following the "syringe driver procedure" that was easily seen in	F 658	4. The DON or designee will conduct random audits of syringe driver applications by Prairie Lakes Healthcare hospice staff on a weekly basis for four weeks, followed by monthly audits for two months, to ensure policy adherence. Results of audits will be reported to the QAPI committee every month for review and continued oversight. Further corrective action will be taken if trends are identified. 5. All corrective actions will be completed by July 8,2025.	

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F 658	Continued From page 2 the syringe driver kit. 3. Interview on 6/11/25 at 2:00 p.m. with director of nursing (DON) B and staff development coordinator C revealed: *Training was provided to new employees on how to operate syringe drivers. *Training was not provided to travel staff prior to working shifts. *It was the expectation of staff development coordinator C, that travel staff were educated through their employment agency. *It was DON B's expectation for LPN F to read the syringe driver procedure and ask for help if needed. *She confirmed this was a medication error. 4. Interview on 6/11/25 at 6:30 p.m. with LPN E revealed: *He worked the shift on 5/12/25 prior to LPN F taking over and he gave a shift report to her that evening. *He had never worked with LPN F before that day. *He informed LPN F when the syringe would need to be changed for resident 1, and asked if she had questions. *He asked LPN F if she was familiar with syringe drivers and how to prepare the medications, and LPN F reported to him that she was familiar with syringe driver use. *He reported education was completed as part of new employee competencies and usually at the annual skills fair. 5. Review of the provider's undated "syringe driver procedure" revealed: *"1. Obtain initial doctor's orders" *"2. Assemble equipment: syringe driver, battery	F 658		

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F 658	Continued From page 3 (9-volt), softest (needleset), 12cc (cubic centimeter) syringe, betadine [cleaning solution], alcohol wipes, transparent dressing/opsite [adhesive dressing], tape, bag, pin, sterile water, MS [morphine sulfate]/Haldol [antipsychotic medication]/Robinol [saliva and secretion reducing medication]" 3."Fill syringe with MS, then sterile water, then Haldol, then Robinol if ordered to an amount to equal 10cc or 12cc." 6. Review of the providers September 2018 medication administration policy revealed: *Instructions, C, 4, "If unfamiliar with the med [medication], check in the drug handbook, call the Pharmacist and/or physician for clarification or look for manufacturer guidelines if it is a recently released med."	F 658		