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

PRINTED: 11/08/2023
FORM APPROVED
OMB NO. 0938-0391

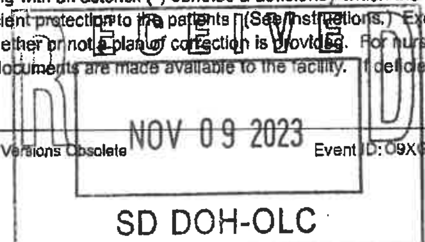
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING ______ B. WING ______	C 10/06/2023

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 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/3/23 through 10/6/23. Jenkin's Living Center was found not in compliance with the following requirements: F625, F641, F657, F684, F710, F726, 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 10/3/23 through 10/6/23. The area surveyed was quality of care. Jenkin's Living Center was found in compliance. On 10/4/23 at 5:00 p.m., immediate jeopardy was identified related to assessment for use of mechanical lifts and body slings at F684. On 10/5/23: *At 11:59 a.m. administrator A provided their plan for the removal. *At 12:05 p.m. the provider's removal plan was accepted by the survey team. *At 12:35 p.m. the survey team determined the immediacy was removed. The resident census was 72.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 625	1. Resident 18, identified in 2567, provided a bed hold policy by social services on 10/24/2023. The resident voiced their understanding of the facility's process if the resident would need to decide on bed hold in the future.	AOC Date: 11/02/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kasey Kleppmodt
TITLE: President / CEO
(X6) DATE: 11/08/2023

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.



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 10/06/2023

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 625	Continued From page 1 specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (18) had received notification of a bed hold notice upon transferring out of the facility. Findings include: 1. Observation and interview on 10/3/23 at 10:27 a.m. revealed she: *Was seated in her recliner watching television. She was alert and oriented to person, place and time. *Was aware that she had been transferred to the hospital several times for fluid retention which had resulted in shortness of breath and an altered mental status. *Stated she was sick, " I do not remember if I had	F 625	2. Audit completed in the review of residents transferred from the facility within the last month. No residents were identified to have not received notification of bed hold upon admission. 3. Education is given by the administrator to DON and ADON. Education is then given by DON and ADON or designee to nurses, social services, and admission coordinator. Education states that residents must be notified of the facility bed hold policy when they transfer from the facility. Verbal or signed consent must be obtained from the resident if they can or the resident representative if the resident cannot—education was provided in nursing staff meetings on 10/26/2023 and 10/27/2023. Education is also sent out through the Paycom online portal used by staff, and this will be the way to track the completion of education. The DON or designee will conduct audits twice a week for 3 weeks, then once weekly for two months. 4. Results of initial as well as ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for three months	

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 10/06/2023

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 625	Continued From page 2	F 625		

been informed about a bed hold."

Review of resident 18's electronic medical record and paper chart revealed:
*She had been transferred to the hospital on 1/23/23, 8/5/23, and 9/11/23.
*There was no documentation found that her family had been notified of any bed hold notices for her transfers out of the facility.
*8/17/23 Minimum Data Set significant change assessment revealed her Brief Interview for Mental Status score was 14; which indicated her cognitive status was intact.

Interview on 10/05/23 at 2:45 with licensed practical nurse X revealed the bed hold notice document might have been located in front of her paper chart or behind her room door.

Interview on 10/5/23 at 3:00 p.m. with assistant director of nursing C revealed the bed hold notice would have been sent with the residents transfer paperwork to the hospital. Social services would have documented in the resident's progress notes when the resident and/or the resident's representative was notified of the bed hold policy. No follow up was done to get the signed bed hold documents returned to the facility.

Interview on 10/05/23 at 3:24 p.m. with social service designee W revealed the nurses should have sent the bed hold notice with the transfer paperwork for resident 18.
Social services would then document the conversation of the bed hold notification with the resident and/or resident's representative in the resident's progress notes.

Review of the provider's May 2018 Bed- Hold

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 10/06/2023

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 625	Continued From page 3 Policy and Readmission After Exceeding Bed -Hold Days revealed: *"A Resident's bed will be reserved upon request in the event he or she is hospitalized with the understanding that the charge for holding the bed." *There was no further information in the policy that specified who would have been responsible for the bed hold notification.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the provider failed to ensure two of two sampled residents (7 and 50) were assessed accurately for weight (wt) loss and accurate Minimum Data Set (MDS) coding. Findings include: 1. Record review of the long term care survey process MDS indicator revealed: *Resident 7 was triggered for wt loss. *That indicator would have been triggered from the last accepted MDS assessment. Observation and interview on 10/3/23 at 9:05 a.m. with resident 7 while sitting in her recliner revealed: *She has had some weight loss recently. *She does not have any problems with chewing or swallowing food. *Review of the resident 7's electronic medical	F 641	1. Residents 7 and 50 identified in the report reviewed weights and corrections to MDS for the accurate weight in the MDS assessment on 10/16/2023. With review, resident 50 was provided with supplement BID with meals. Resident 7 had no adverse reaction to weight inaccuracy documentation in MDS.	AOC date: 11/2/2023

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 10/06/2023

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 641	Continued From page 4 record (EMR) on 10/3/23 regarding wt loss revealed the following documentation: *On 7/5/23 a weight of 168 pounds using the bath. *On 7/17/23 a weight of 145 pounds using the bath scale had been documented that was a -13.69% wt loss. *On 8/1/23 resident 7's quarterly MDS was accepted with the weight of 145 pounds recorded. *On 9/6/2023 a weight of 171 pounds using the bath scale. *On 9/27/2023 a weight of 145.5 pounds using the bath scale had been documented that was a -14.91% loss. *She had been weighed weekly. Interview on 10/5/23 at 2:30 p.m. with licensed practical nurse (LPN) M regarding resident wt loss revealed: *She would re-weigh the resident if there was a significant change in the wt. *If the wt was found to have been correct after the re-weigh then she would: -Send a notification to the physician regarding the weight change. -Send a notification to the dietary manager. -Watch for any new orders or recommendations. *LPN M had reviewed resident 7's documented weight on 9/6/23 through 9/27/23. *She agreed that was a significant weight change. *She had not been able to find a progress note regarding the weight change. Interview on 10/5/23 at 2:49 p.m. with assistant director of nursing (ADON) C regarding significant wt loss for a resident revealed: *Staff should have re-weighed the resident upon discovering the wt loss. *Her expectation would have been that a	F 641	2. Education is given by DON, ADON, and administrator to the dietician, dietary manager, and MDS coordinators on proper weight documentation in MDS assessment, with two-level checks on weight in MDS before MDS submission. When MDS is due, the dietician will review historical weights in PCC to ensure that the weight in MDS is accurate before submission. MDS coordinators will verify with the dietician before closing MDS. With review and update by the administrator, DON, IDT, and medical director, the updated policy addresses potential resident weight loss and ensures the accuracy of weights. The facility also purchased a new scale to ensure that all scales used are the same type and that the process will be the same for each resident being weighed—education was provided in nursing staff meetings on 10/26/2023 and 10/27/2023. Education was also sent out through Paycom online portal on 10/27/2023; this will be the way to track education completion. 3. Audits will be completed by the DON, ADON, or designee of the MDS accuracy conducted two times a week for 3 weeks, then once a week for two months. 4. Results of initial as well as ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for three months.	

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 10/06/2023

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 641	Continued From page 5 progress note should have been made by the nurse acknowledging the wt loss. *She would expect the physician and dietary to have been notified. *A copy of the fax that would have been sent to the physician with notification of the wt loss should have been in the resident's paper chart. Interview on 10/6/23 11:16 a.m. with registered dietitian (RD) D, administrator A, director of nursing (DON) B regarding resident 7's wt loss revealed: *RD D felt that her clinical judgement of the resident's wt variances had not needed to have been documented. *She had known that resident 7's wt variance was not correct due to her dietary intake, but had not documented that information in a progress note or communicated that to the nursing staff. *Administrator A felt that documentation of RD D's reviews of resident's wt variances was necessary. 2. Observation and attempted interview on 10/5/23 at 2:42 p.m. with resident 50 while certified nursing assistant (CNA) I assisted him to the restroom revealed: *He was seated in a Broda (specialized wheelchair) chair. *He was non-verbal and was unable to answer questions. *He had on sweatpants and a shirt that appeared to be loose on him. Review of resident 50's EMR revealed his: *Brief interview of mental status score had not been determined, as he was unable to complete the interview. -A staff interview on 9/11/23 had been completed that determined he had severe cognitive impairment.	F 641		

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 10/06/2023

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 641	Continued From page 6 *Weight (wt) record revealed the following documentation: -On 4/26/23 as 198.6 pounds. -On 8/20/23 as 195.8 pounds. -On 8/25/23 as 183.8 pounds. -On 9/9/23 as 180.8 pounds. -On 9/16/23 as 180.4 pounds. -On 9/23/23 as 179.6 pounds. -On 9/30/23 as 179.4 pounds. *From 8/20/23 to 9/30/23 he had a wt loss of 8.38% Interview and record review on 10/5/23 at 3:06 p.m. with LPN K regarding resident 50's wt loss revealed: -She thought he had lost wt, "Just by looking at him". *His EMR noted that he had lost about 20 pounds since April 2023. *She had not reported his wt loss to the physician or the registered dietitian (RD). On 10/6/23 at 1:00 p.m. RD D provided documentation that resident 50 had been reweighed on 10/6/23 at 10:39 a.m. and his weight was 179.4 lbs. Interview and resident assessment instrument (RAI) manual review on 10/6/23 at 3:32 p.m. with DON B regarding coding for wt on the resident's Minimum Data Set (MDS) revealed: *Resident 50's wt on his 9/12/23 MDS was recorded as 196 pounds. *His most recent wt in the last 30 days for the 9/12/23 MDS should have been recorded as 181 pounds, that was a 15-pound discrepancy. *She agreed the MDS was coded incorrectly. *She had no training on how to complete the MDS.	F 641		

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 10/06/2023

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 641	Continued From page 7	F 641		

*RD D would have been the one to complete the wt section on the MDS.

Interview with RD D and on 10/6/23 at 3:55 p.m. regarding coding for resident's wt on the MDS revealed she:
*Had completed the wt section on resident 50's 9/12/23 MDS.
*Agreed resident 50's wt on that MDS had not been coded correctly.
*Was unsure as to why she had used the 196 pounds as his wt.
*Stated she followed the resident assessment instrument manual instructions for completion of the MDS.
*Agreed using the 196 pounds as his wt was not following the instructions of the RAI for completing the MDS.
-The instructions included using the most recent wt closest to the assessment reference date.
-The assessment reference date for that MDS was 9/12/23.
-She agreed she should have used his wt that was recorded from 9/9/23 of 180.8 pounds rounded up to 181 pounds as the RAI manual had instructed.

Interview with administrator A on 10/6/23 at 4:00 p.m. revealed his expectations was for staff members to follow the instructions in the RAI manual for completion of the resident's MDS.

Review of the provider's undated Weight Change Summary Report policy revealed:
*"A significant wt change report is sent to care conference members and printed to the nurses' stations at least monthly."
*"Significant changes are defined as 5% or more in one month and 10% or more in 6 months. 7.5%

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 10/06/2023

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 641	Continued From page 8 in 3 months is also considered a significant change but is not coded on the MDS as such." *"Information is requested from the care conference team regarding possible underlying causes of wt changes as well as possible interventions." *"Interventions may include (but not limited to): -Reweighing the resident. -Interviewing the resident or direct care-givers. -Reviewing the medical records, labs, history. -Referrals to appropriate care team members. -Reviewing food intake records. -Referral to the quality of life committee. -Nutritional supplementation. -Reviewing the care plan." Review of the provider's undated documentation of resident's nutritional care policy revealed: *"Policy: -Documentation of resident's nutritional care is the responsibility of the Dietary Professional (Registered/Licensed Dietitian). --Nutritional Assessments are completed per state and federal guidelines. The Assessment may include (but not limited to) information on wt status, acute and chronic health conditions, medications, labs, diet, preferences, dental status and interventions appropriate to nutritional status. --Initial Plan of Care is completed within 7 days after completion of the MDS. --A new Nutritional Assessment and Plan of Care is completed each time a resident is re-admitted (or per MDS criteria), and as deemed necessary by the facility or the Registered and/or Licensed Dietitian."	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657	1. Residents 28, 29, 41, 50, and 67 identified in the report updated the identified issues in the care plan with care plan documentation to reflect the current care plan for residents.	AOC Date: 11/7/2023

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 10/06/2023

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 657	Continued From page 9 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow, revise, and update care plans for five of twelve sampled residents (28, 29, 41, 50, and 67) to reflect their current care needs. Findings include: 1. Observation and interview on 10/03/23 at 4:35 p.m. with resident 28 in her room revealed: *The resident was in her room seated in her wheelchair.	F 657	2. The facility will conduct care plan meetings with the IDT team twice a week and will have all care plans reviewed and updated by 11/7/2023. After all residents have been reviewed, a care plan meeting will be held once a week, and the sample residents will include residents identified to have a change in condition or care or identified by floor staff for review. Care plans will be updated and communicated to floor staff if changes occur. 3. Education provided by DON, ADON to social services, and IDT teams for timely care plan updates and monitoring. The care plans should accurately represent the care given to the resident and be updated in a timely manner. Education was also sent out through Paycom online portal on 10/27/2023; this will be the way to track the completion of education. Audits are completed by DON, ADON or designee twice a week for 3 weeks, then once weekly for 2 months. 4. Results of initial as well as ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for three months.	

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 10/06/2023

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 657	Continued From page 10	F 657		

*Her room was dark with the door opened a few inches.
*During the interview she was observed to have a flat affect (restricted or nonexistent expression of emotion).
*She thought she had moved into the facility about six months ago.
*The reason she was admitted was because she had a fall at home that resulted in a broken hip.
*She was at the facility for rehabilitation but had not made enough progress in her therapy to return to her home.
*It was a hard transition for her that resulted in increased anxiety and depression.
*She wanted to return to her home.

Review of resident 28's electronic medical record (EMR) revealed she:
*Had a Brief Interview for Mental Status score of 14 that indicated her cognition was intact.
*She had a history of mental health issues.
*Her diagnoses included the following:
-Anxiety disorder.
-Depression.
-Adjustment disorder with mixed disturbance of emotions and conduct.
-Agoraphobia (a type of anxiety disorder) with panic disorder.
-Insomnia.
*There had been a 9/14/23 progress note from social services that resident 28 had stated she wanted to die.
*On 9/18/2023 social services charted the following:
-"Note text: quarterly charting for ARD [Assessment Reference Date] date of 9-12-2023. [resident name] did her own interview questions. Her BIM'S score was 14 as she needed a cue on one of the words. PHQ-9 was higher as she is

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 10/06/2023

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 657	Continued From page 11 spending her time in her room due to Covid in facility. She did tell me she felt she would be better off dead though she did say she wouldn't hurt herself. I did fax over to her doctor and he noted it and no further orders received. We will monitor for changes. During our conversation she did initiate a little more than usual. She is on psychotropic meds. Her daughter visits often." *She was followed by a psychiatrist on a regular basis to address her mental health needs and had been seen since she had admitted to the facility. Interview on 10/04/23 at 9:15 a.m. with licensed practical nurse (LPN) F regarding resident 28 revealed: *The resident received medication to address her mental health issues. *She had always known her to have had a flat affect. *She had been seen and followed up by her psychiatrist and physician after the 9/14/23 suicidal statement. *The resident had a difficult time with the transition when she admitted and had been depressed. *If the resident made statements about wanting to die it would have been reported to her physician. *She was not sure if her history of suicidal ideation had been included on her care plan or if there had been a task for the CNAs to have documented concerns regarding her current mental health status. Interview on 10/05/23 at 3:04 p.m. with CNA V regarding resident 28 revealed: *The tasks for residents were assigned onto a Kardex system for the CNAs to complete for those residents that they provided care to.	F 657		

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 10/06/2023

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 657	Continued From page 12 *She thought the assignments were made according to the resident's care plan. *There had been a task to report if she had been angry but nothing that related to sadness or anxiety. *When the resident first admitted she had been more needy and lonely and tended to use her call light often. *Now she participated in activities on a regular basis and seemed more satisfied with her current living arrangements. Review of resident 28's revised 9/12/23 comprehensive care plan revealed: *It had included the following: -She received psychotropic medications and staff were to have monitored for side effects, including suicidal ideation. -Interventions on how to assist her when she refused care or had displayed verbal or physical aggression. -Her interests for group and individual activities she enjoyed. *It had not included information about her personal history that she had made suicidal statements or instructions for staff on what behavior changes to have observed that would alert the staff that she might have been experiencing an emotional crisis. Interview on 10/06/23 at 8:22 a.m. with agency CNA R regarding resident 28 revealed: *The following interventions were included for tasks to chart on for the resident including: -Frequent crying, repeats movement, yelling/screaming, kicking and hitting, pushing, grabbing, pinching, scratching, spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate, rejection of care.	F 657		

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 10/06/2023

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 657	Continued From page 13 *There was no interventions related to her moods such as sadness, loneliness, or anxiety. *She never known the resident to make statements that she wanted to die or that it was in her history, but thought it would have been important information for the staff to have been aware of. 2. Review of resident 67's EMR revealed: *She was admitted on 4/27/23 for rehabilitation for a stroke. *During rehabilitation she suffered further mini strokes (TIAs) that caused her to decline further. *She had right-sided weakness with no physical ability to move or use her right arm or the right leg. *She was able to eat independently but due to her decline in May 2023 they had added an intervention for staff to assist her with eating meals. *She was placed on hospice care on 7/17/23. Observation on 10/4/23 at 8:20 a.m. with resident 67 in her room revealed: *She had been in her room seated in her recliner with her breakfast tray in front of her on the bedside stand. *She had been eating and drinking out of a cup using her left hand. *Staff were not assisting the resident to eat. Observation on 10/6/23 at 8:50 a.m. with resident 67 in her room revealed: *The resident had been seated in her recliner with her bedside stand in front of her. *A CNA brought in her breakfast tray and set it up for her and then left the room. *She had not made an attempt to assist the resident with eating.	F 657		

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 10/06/2023

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 657	Continued From page 14 *The resident then ate her food using her left hand. Interview on 10/3/23 at 9:20 a.m. with LPN F regarding resident 67 revealed: *She was on hospice services since 7/17/23. *The hospice staff would come in to assist her with care. *The resident insisted on feeding herself and the CNAs respected her wishes. *She was evaluated by speech therapy for her swallowing function. *They tried to change the texture of her food to have made it easier for her to eat but she refused to eat anything but regular textured foods. *She had been very independent. *She would let staff know her needs by pushing things on the floor if she was displeased. *Her family had been very involved in her care. *She was not aware if the care plan included her wanting to eat on her own but the CNAs were aware and would let her eat independently. Review of her current care plan revealed she was to have a one person assist with her meals. *That had not been observed. *Her care plan had not been updated to reflect her current care needs. 3. Observation and interview on 10/5/23 at 2:42 p.m. of resident 50 with CNA I revealed he: *Smiled and had not responded to questions. *Was not wearing glasses. -CNA I was not sure where his glasses were. *Had been seated in a rocking wheelchair. *Had a Foley catheter drainage bag hanging from the bottom bar of his wheelchair. *Had required the use of a mechanical sit-to-stand mechanical lift for transfers. -CNA I assisted him from his wheelchair to a	F 657		

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 10/06/2023

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 657	Continued From page 15 sit-to-stand mechanical lift. --There was no other staff member present to assist CNA I. --The resident had difficulty placing his hands around bars of the sit-to-stand lift. --He was able to hang onto the bars once CNA I placed his hands on those bars. --CNA I then assisted the resident into the bathroom. --Upon returning him from the bathroom CNA I: ---Returned him to his wheelchair. ---CNA I washed her hands and, ---Moved the sit-to-stand mechanical lift and body sling into the hallway. ----CNA I had not disinfected the sit-to-stand mechanical lift or the body sling. Review of resident 50's EMR revealed: *He was admitted on 1/21/21. *His BIMS score had not been determined, as he was unable to complete the interview. -A staff interview on 9/11/23 had been completed that determined he had severe cognitive impairment. *His diagnoses included: Alzheimer's disease, dementia with agitation, history of urinary tract infections, and obstructive and reflux uropathy (which occurs when urine cannot drain through the urinary tract). Review of resident 50's 10/5/23 care plan in his EMR revealed: *There was an initiated 6/28/23 focus that included, "Risk factors include: cognition, lactose intolerance,B12 anemia [intolerance, B12, and anemia]." --The 6/28/23 goal for that focus was, "No weight goal during hospice." ---He had been discharged from hospice on	F 657		

F 657 | Continued From page 16 | F 657

2/28/23.
*A revised 9/28/22 intervention for toilet use that included, "has an indwelling catheter. He needs 2 staff assist with toileting [toileting]."
*A revised 4/5/22 focus of, "has an Indwelling Catheter: He has a diagnosis of BPH with urinary obstruction."
-An initiated 2/1/21 intervention for that focus that included, "Monitor and document intake and output as per facility policy."
*A revised 12/13/23 focus that included, "Unable to assess [residents name] vision due to advanced dementia. When asked, he stared blankly at the sheet with no response at all."
-The revised 6/1/23 goal that included, "will show no decline in visual function through the review date."
--The 2/9/21 intervention that included, "remind to wear glasses when up. Ensure [residents name] is wearing glasses which are clean, free from scratches, and in good repair. Report any damage to nurse."

Interview on 10/05/23 at 3:03 p.m. with LPN K regarding resident 50 revealed:
*He had worn glasses.
-He stopped wearing them "at least a year ago."
--She was not aware as to why he quit wearing them.
*Regarding his weight loss:
-Their process was:
-Complete an assessment to determine if the weight was related to:
--A fluid gain or loss.
--Eating less food.
-To have documented that the dietitian and the physician were notified.
*She thought he had lost weight, "Just by looking at him".

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

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 10/06/2023

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 657	Continued From page 17	F 657		

*His EMR noted that he had lost about 20 pounds since April, 2023.
*His weight since the beginning of August, 2023 had varied.
-He was assisted by a staff member when eating his meals.
-He would sometimes grab foods that were finger foods.
-He had normally eaten 75 to 100 percent of his food.
*She had not reported his weight loss.

Interview on 10/06/23 at 8:16 a.m. with administrator A and DON B regarding resident 50's care plan revealed:
*DON B stated he had been on hospice from 9/8/22 through, she believed "12/27/22".
-The care plan should have been updated with his MDS completed after the date of his discharge from hospice.
-He had glasses but had not worn them for at least six months.
--DON B confirmed he had taken them off his face and thrown them on the floor the last five to six times when staff attempted to have him wear them.
---That was at least two months ago.

*MDS coordinator U would have been responsible to update the care plan.
-DON B and ADON C would have been able to update the care plan.
-They agreed the care plan:
--Should have been updated to include that the resident no longer wore his glasses.
--Stated in two different sections that he was on hospice and he was not on hospice.
---They had not felt that the discrepancy in his care plan was a concern.

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 10/06/2023

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 657	Continued From page 18	F 657		

Interview on 10/06/23 at 8:38 a.m. with administrator A, DON B, ADON C, and RD D revealed regarding resident 50's weight loss:
*RD D had not felt that his weight loss was a concern.
-She stated his weight was above his admission weight which had been 164 pounds.
-He had gained weight after his admission.
--He had been admitted to hospice for a period of time.

Interview on 10/6/23 at 4:31 p.m. with administrator A, DON B, MDS coordinator U regarding resident 50's Foley catheter output on his care plan revealed:
*DON B agreed the care plan included to follow the provider's policy for recording of urinary output from the Foley catheter.
-Agreed the provider's policy referred to in the care plan, for catheter intake and output did not include how to measure or record output from a Foley catheter.

Continued interview on 10/6/23 at 4:49 p.m. with Administrator A, and DON B, and MDS coordinator U regarding resident care plans revealed:
*Care plans were updated when the MDS was completed.
*Nurses would communicate to the MDS coordinator if there were changes in the resident's care.
*They would have expected the care plan to accurately reflect the current care the resident was receiving.

4. Observation and interview on 10/03/23 at 9:34 a.m. with resident 41 revealed:

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 10/06/2023

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 657	Continued From page 19 *She was seated in her recliner with pillows positioning her to sit upright. *She stated her room, "is noisy at night". -She thought the noise had come from the bed and occurred about every fifteen minutes. --The bed had an electronic low air loss mattress on it and had been making a loud humming noise. -She stated, "A man brought in and slapped it on the bed and left". -She had always slept in the chair, stated "I never sleep in the bed." --Staff would reposition her with pillows. Review of resident 41's EMR revealed: *She was admitted on 8/29/23. *Her BIMS score was a 14, meaning she was cognitively intact. *Her revised 9/23/23 care plan included that she required the following: -Required one staff member to assist in turning and repositioning her in bed. -Needed her bed in the low position at night. -Used a low air loss mattress on her bed for pressure ulcer prevention. 5. Observation and interview on 10/3/23 at 3:15 p.m. with resident 29 revealed he: *Was sitting in his recliner watching T.V. *Required toilet assistance. *Denied having any treatments for skin problems. Interview on 10/5/23 at 2:30 p.m. with licensed practical nurse (LPN) M regarding resident 29's toileting schedule revealed: *He would have been assisted to the toilet at these times: -Upon waking up and before going to breakfast. -After breakfast and before lunch. -After lunch and before activities.	F 657		

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 10/06/2023

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 657	Continued From page 20 -After activities and before supper. -After supper. -Any time that he had requested to use the toilet. *She had not indicated that resident 29 had any problems with his skin. Interview 10/6/23 9:35 a.m. with LPN N regarding resident 29's skin revealed: *She stated that at times he would have redness on his buttocks. *Staff would have applied an ointment to his buttock, * He does not have any chronic skin issue with redness. Review of resident 29's EMR revealed: *He was admitted on 1/6/23 and had not been diagnosed with MASD (moisture associate skin disorder) or urinary incontinence. *On 1/6/23, day of admission the skin observation record indicated skin was dry. *On 3/23/23 and 6/22/23 he had dry skin. *On 9/22/23, the record indicated he had bruising to bilateral eye, skin tears to the right eye and right forehead, abrasion to his left knee, but no documentation that indicated he had MASD. *On 3/27/23 and 9/22/23 bowel and bladder screening record indicated he was determined a candidate for bladder retraining. *On the 6/22/23 screening, it was determined he was a candidate for scheduled toileting. Interview on 10/5/23 at 4:30 p.m. with DON B and ADON C regarding bowel and bladder assessments and skin record observations revealed: *That assessment was used for the MDS. *It was not a nursing care tool.	F 657		

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 10/06/2023

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 657	Continued From page 21	F 657		

Review of resident 29's care plan revised on 4/5/23 revealed:
*"Resident 29 is at risk for altered skin integrity related to her {sic} needing assist with his bed mobility and having MASD to his coccyx/gluteal folds."
*"Resident 29 has complaint of, depending on how he sits, having pain to his "bottom"."
*" He is currently being treated for MASD to his coccyx."

Interview 10/6/23 4:49 p.m. with MDS coordinator U, administrator A, and DON B regarding updating resident 29's care plan to his current needs revealed:
*MDS coordinator U would have updated the care plan with the quarterly MDS, and if someone would have informed her for the need update or revise the care plan.
*DON B stated that staff were still performing interventions, but agreed that was not an active problem and that the resident was at risk for MASD.
*Administrator A agreed that the resident care plans should reflect the current care needs of the resident.

Review of the provider's April 2020 Care Plan, Resident-Centered Facility Standards of Care revealed:
*"The following are standards of nursing care that should be provided by certified nursing assistants, staff nurses, director of nursing and nursing home administrator in the nursing home setting:"
-"Provide an accurate assessment and individualized care plan for each resident."
-"Recognize abnormal changes in body function and the importance of reporting such changes to

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 10/06/2023

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 657	Continued From page 22 the physician." -"Ensure appropriate and safe transfers, positioning and turning." *"At Jenkins Living Center long term care plans are developed by an interdisciplinary team (IDT) with input and participation of CNA's, the resident, family and/or legal representative (when available) ...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 revisited after each assessment and PRN [as needed]. The short-term care plan is reviewed during this time and long term issues are carried forward to the long term care plan as applicable." *"Each discipline is responsible for updating the care plan as changes occur between assessments and scheduled care conferences updates may occur via short-term care plan or PCC care plan. Care plan changes may be made by Nurses (with the input of C.NAs as indicated), Social Workers, Therapy ..., Activity Director, Activity Coordinator (Reflections and Activity Aides, Dietary Director and Dietary Managers. Communication between the IDT, residents and families is ongoing and occurs as needed."	F 657		
F 684 SS=J	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	F 684	1. Initial assessments were conducted on 10/5/2023 for all residents by DON, SDC, MDS RN nurses on all residents requiring a mechanical lift to determine proper sling size, type of mechanical lift, and number of staff needed for transfer.	AOC: 11/7/2023

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 10/06/2023

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 684	Continued From page 23 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, South Dakota Department of Health (SD DOH) incident report review, and manufacturer's recommendations review, the provider failed to ensure one of one sampled resident (13) was assessed for the appropriate lift type Maxi Move (a mechanical device used to transfer residents), the correct size of sling, and the number of staff required to perform a transfer with a Maxi Move lift safely. Findings include: On 10/4/23 at 5:00 p.m. an immediate jeopardy was identified related to quality of care F684. Notice: Notice of immediate jeopardy was given verbally and in writing on 10/4/23 at 7:00 p.m. to administrator A and director of nursing (DON) B and assistant director of nursing (ADON) C. On 10/4/23 at 5:00 p.m. an immediate jeopardy was determined when the facility failed to ensure the following: *"A resident assessment for proper mechanical lift equipment use and the number of staff required to operate the lift equipment safely was followed by manufactures recommendations which include:" -"A clinical assessment of the patient's suitability for transfer must be carried out by a qualified health professional considering that, among other things, that transfer may induce substantial pressure on the patient's body. A transfer conducted when it should not, can degrade the patient's health condition."	F 684	This was completed for all residents using a mechanical lift on 10/5/2023. 2. Education initiated on 10/4/2023 provided by DON, ADON or designee to all nursing staff and therapy services before their next working shift. Nursing assistants will notify the charge nurse if there is a change in the resident's condition. This would trigger a mechanical lift assessment form be completed by a health professional (RN,PT,OT). This assessment will be accessible through nursing station computers or can be requested from DON. The assessment will determine whether sit-to-stand or Total Lift is required. If a mechanical lift is needed, the size of the sling and the personnel necessary for transfer are either one or two staff. Mechanical lift recommendations will be communicated to staff through a daily morning huddle, and a pocket care plan that will be monitored and updated by DON and IDT. Mechanical lift competencies completed with nursing staff by SDC, DON, ADON, or designee through mechanical lift checklist by 11/7/2023 or before the staff members' next working shift. 3. DON, ADON, designee will conduct audits to ensure that proper transfer protocol for mechanical lifts is being followed. DON, ADON, designee will conduct audits twice a week for 3 weeks, then once weekly for 2 months.	

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

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 10/06/2023

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 684	Continued From page 24 *"The need for a second attendant to support the patient must be assessed in each individual case." *"There are circumstances, such as combativeness {sic}, obesity, contractures etc. of the individual that may dictate the need for two-person transfer. It is the responsibility of each facility or medical professional to determine if a one or two transfer is more appropriate, based on task, resident load, environment, capability, and skill members." *"Ensure that certified nurse assistant are not assessing for the resident's suitable for transfer." *"Ensure that residents who require the use of the mechanical lift are also assessed for the proper sling size to be used during transfers." *"A resident 13 who had not been assessed for safe mechanical lift use, fell from a mechanical lift on 7/12/23 while being transferred by one staff member and sustained a head injury." *"All residents who require the use of a mechanical lift have the potential for harm as a result of not having been assessed for the use of a mechanical lift and include the specific number of staff to safely operated the mechanical lift." *"Ensure that residents who require the use of a mechanical lift have been assessed for the specific number of staff required to ensure the safety of the resident while being transferred with a mechanical lift." *"Assessments will need to be completed by a licensed healthcare professional (RN, PT, OT)." *"Ensure that residents who require the use of the mechanical lift are also assessed for the proper sling size to be used during transfers." On 10/4/23 at 7:00 p.m. administrator A, DON B and ADON C were asked for an immediate removal plan.	F 684	4. Results of initial as well as ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for three months.	

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

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 10/06/2023

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 684	Continued From page 25 Plan: 1. "Initial assessments were conducted on all residents requiring a mechanical lift on 10/5/23." "Educated nurses, CNAs, therapy services, and nursing management on assessing when a resident requires a mechanical lift for transfer. Nursing staff will be responsible for communicating a change in condition for resident's transfer status requiring a mechanical lift. An assessment will be initiated to determine if a resident requires a sit-to-stand lift or full-body lift. If a full-body lift is determined, the assessment will indicate the appropriate size of the sling and if the resident requires one or two people while operating the full-body lift. The IDT team will evaluate the change in transfer status with therapy. Care plan will be updated to show appropriate transfer status. Education initiated on 10/4/23 will be provided by DON, ADON or designee to all nursing staff and therapy services prior to their next working shift. Education provided to staff. Nursing assistants will notify the charge nurse if there is a change in the resident's condition. This would trigger a clinical assessment by a health professional. The assessment will determine whether sit-to-stand or total lift is required. If a full-body lift is needed, the size of the sling and the personnel necessary for transfer are either one or two staff. Mechanical lift recommendations will be communicated to staff through a daily morning huddle, and the care plan will be updated in PCC." 2. "An initial audit will be conducted by DON, ADON, or designee on all residents who currently require mechanical lift. This audit will review the initial assessment for proper lift and if the total body lift is required the fit of sling and the appropriate staff needed to operated the full body	F 684		

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 10/06/2023

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 684	Continued From page 26	F 684		

Continued From page 26
lift."
3. "Compliance date 10/5/23."

On 10/5/23 at 11:59 a.m. the provider's immediate jeopardy removal plan was accepted.

On 10/5/23 at 12:35 p.m. while onsite the immediacy was removed.

Once the immediacy was removed the scope and severity was changed to a "G".

Interview on 10/3/23 at 10:45 a.m. with resident 13 revealed:
*She had fallen from the Maxi Move lift and had obtained a cut to the back of her head.
-Her head laceration required an emergency room (ER) evaluation and two staples to close the wound.
*She did not think that all the straps were secured to lift and that was why she fell out of the lift.
*Only one certified nurse aide (CNA) was transferring her at that time with the Maxi Move lift.

Review of resident 13's electronic medical record (EMR) revealed:
*She had a Brief Interview for Mental Status (BIMS) score of 12 suggesting she had moderate cognitive impairment.
*She had the following medical diagnoses:
-Post-polio symptoms.
-Hemiplegia (loss of the use of limbs on one side of the body) affecting the right side of her body.

Review of resident 13's care plan initiated on 3/7/2018 revealed:
*"Focus: Resident 13 is at risk for fall related to

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 10/06/2023

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 684	Continued From page 27	F 684		

her taking psychotropic medication to treat her diagnosis of depression."
*Interventions: Resident 13 chooses to use the standing lift versus the total lift. She is at risk for falls and significant injury secondary to her insisting the seat strap not be used."
-"She had been instructed on the risk associated with not using the seat strap however she stated "I will deal with that".
*"Focus: Resident 13 has an activities of daily living (ADL) self-performance deficit related to her decreased mobility and need for assistance with all of her ADL's. She had physical impairments related to her diagnosis of polio."
*"Intervention: Toilet use: one to two total assist. Staff will toilet resident 13 per the care plan standard. She will be seated on the toilet with the assistance of the total lift when she prefers to use the restroom."

Review of the SD DOH incident report submitted on 7/13/23 revealed:
*On 7/12/23 at 11:00 a.m. resident 13 was transferred using the Maxi Move lift from her bed to her motorized wheelchair by one CNA.
*Resident 13's weight shifted while lowering her in the Maxi Move lift causing one of the four hooks to become unhooked resulting in her falling from the total lift to the floor in her room.
*The resident was transferred to the ED for evaluation and closure of the laceration with two staples to back of her head.

Interview on 10/4/23 at 11:00 a.m. with an anonymous employee regarding transferring residents with the Maxi Move lift revealed:
*Staff felt uneasy about transferring a resident with the Maxi Move lift with just one person.

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

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 10/06/2023

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 684	Continued From page 28 *Staff would ask another staff member for help with transferring a resident with the Maxi Move lift. -Staff had never refused help from another staff member while transferring a resident with the Maxi Move lift. Interview on 10/4/23 at 1:00 p.m. with CNA H regarding transferring a resident with the Maxi Move lift revealed: *She had worked at other facilities that required two staff members to transfer residents with the total lift. *She would have made the decision depending on the resident what type of lift would have been required to safely transfer a resident. *The majority of the time she felt that transferring residents with the Maxi move lift was appropriate with one staff member. Interview on 10/4/23 at 3:30 p.m. with administrator A, and DON B regarding CNAs assessing for the type of mechanical lift and the number of staff that would have been required to transfer the residents revealed: *They both felt that the CNAs use the mechanical lift equipment and would have been able to determine what type of lift and the number of staff required to transfer the residents. *The CNAs would have determined the size of the sling to have been used with the resident during a Maxi Move lift transfer. -The sizes of the sling were not determined by the resident's weight but by how the sling fit around the resident. *Resident 13 had not been reassessed for appropriate mechanical lift used for transferring following her fall from the Maxi Move lift. *Her fall was the result of a strap coming	F 684		

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

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 10/06/2023

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 684	Continued From page 29	F 684		

unhooked and there was not an issue with the Maxi Move lift.
*DON B had completed a competency for the Maxi Move lift use with the CNA involved in the fall.
*They had not been aware of the manufactures recommendation that stated " before using the total lift a clinical assessment of the resident's suitability for transfer must be carried out by a qualified health professional."
*They had not assessed the residents prior to using the Maxi Move lift as well the proper sling size for that resident.
*They had not assessed for the correct number of staff required to perform a safe resident transfer using the Maxi Move lift.

Review of the provider's revised 3/2022 Maxi Move lift policy revealed:
*"The total lift will be used correctly and safely with one or more staff assisting, as necessary."
*"Equipment require: total lift and proper fitting sling."
*"Instructions:
-"Correct sling size is important."
-"Make sure the sling is clean and not damaged."
-"Make sure the residents weight is lower than the safe work load for the total lift, slings and accessories used."
-"If a resident becomes agitated, you may need to stop the transfer and safely lower the resident."

Review of the 12/2015 Maxi Move lift instructions for the proper use revealed:
*Safety instructions:
-"Before using the total lift, a clinical assessment of the resident's suitability for transfer must be carried out by a qualified health professional considering, that among other things, the transfer

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

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 10/06/2023

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 684	Continued From page 30 may induce substantial pressure on the resident's body. A transfer conducted when it should not, can degrade the resident's health condition."	F 684		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the provider failed to ensure two of two sampled residents (7 and 50) had physician involvement associated with weight loss. Findings include: 1. Record review of the long term care survey process MDS indicator revealed: *Resident 7 was triggered for wt loss. *That indicator would have been triggered from the last accepted MDS assessment.	F 710	1. Residents 7 and 50 were identified in the report without a physician notification for weight loss. The medical director reviewed both residents on 10/10/2023 through the quality of life, with resident 50 adding a supplement and will review in next month's quality of life meeting. Resident 7 was reviewed by a medical director with no new changes to care added. 2. Education is given by DON, ADON, and administrator to nursing staff if they identify that the resident has weight gain or lost 3lbs to conduct reweighting. If weight discrepancy still exists, then notify the charge nurse. The nurse will then inform the dietician of the weight change. At that time, the dietician will review the resident clinical information and contact the physician if deemed necessary. A new scale was purchased so that all scales used in the facility are the same type and process. Education was provided in nursing staff meetings on 10/26/2023 and 10/27/2023. Education was also sent out through the Paycom online portal on 10/27/2023; this will be how to track education completion.	AOC: 11/3/2023

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

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 10/06/2023

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 710	Continued From page 31 Observation and interview on 10/3/23 at 9:05 a.m. with resident 7 while sitting in her recliner revealed: *She has had some weight loss recently. *She does not have any problems with chewing or swallowing food. *Review of the resident 7's electronic medical record (EMR) on 10/3/23 regarding wt loss revealed the following documentation: *On 7/5/23 a weight of 168 pounds using the bath. *On 7/17/23 a weight of 145 pounds using the bath scale had been documented that was a -13.69% wt loss. *On 8/1/23 resident 7's quarterly MDS was accepted with the weight of 145 pounds recorded. *On 9/6/2023 a weight of 171 pounds using the bath scale. *On 9/27/2023 a weight of 145.5 pounds using the bath scale had been documented that was a -14.91% loss. *She had been weighed weekly. Interview on 10/5/23 at 2:30 p.m. with licensed practical nurse (LPN) M regarding resident wt loss revealed: *She would re-weigh the resident if there was a significant change in the wt. *If the wt was found to have been correct after the re-weigh then she would: -Send a notification to the physician regarding the weight change. -Send a notification to the dietary manager. -Watch for any new orders or recommendations. *LPN M had reviewed resident 7's documented weight on 9/6/23 through 9/27/23. *She agreed that was a significant weight change. *She had not been able to find a progress note	F 710	3. Audits to be conducted by DON, ADON, or designee twice a week for 3 weeks, then weekly for 2 months to review a resident's weight loss or gain. The audit will ensure that if clinically deemed necessary, the physician needed to be contacted, it was documented, and a review by the dietician was conducted. 4. Results of initial as well as ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for three months.	

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

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 10/06/2023

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 710	Continued From page 32 regarding the weight change. Interview on 10/5/23 at 2:49 p.m. with assistant director of nursing (ADON) C regarding significant wt loss for a resident revealed: *Staff should have re-weighed the resident upon discovering the wt loss. *Her expectation would have been that a progress note should have been made by the nurse acknowledging the wt loss. *She would expect the physician and dietary to have been notified. *A copy of the fax that would have been sent to the physician with notification of the wt loss should have been in the resident's paper chart. Interview on 10/6/23 11:16 a.m. with registered dietitian (RD) D, administrator A, director of nursing (DON) B regarding resident 7's wt loss revealed: *RD D felt that her clinical judgement of the resident's wt variances had not needed to have been documented. *She had known that resident 7's wt variance was not correct due to her dietary intake, but had not documented that information in a progress note or communicated that to the nursing staff. *Administrator A felt that documentation of RD D's reviews of resident's wt variances was necessary. *Request was made on 10/4/23 to DON B for a copy of the notification sent to resident 7's physician regarding her weight loss. -She had not been able to produce a the document prior to exit. Resident #7	F 710		

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 10/06/2023

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 710	Continued From page 33 2. Observation and Interview on 10/05/23 2:42 p.m. of resident 50 with certified nursing assistant I revealed he: *Had smiled and did not respond to questions. *Required the use of a mechanical sit-to-stand lift to transfer. -Had difficulty placing his hands on the bars of the lift. Review of resident 50's EMR regarding weight loss revealed: *His weights had been documented: -On 4/26/23 as 198.6 pounds. -On 8/20/23 as 195.8 pounds. -On 9/9/23 as 180.8 pounds. -On 9/16/23 as 180.4 pounds. -On 9/23/23 as 179.6 pounds. -On 9/30/23 as 179.4 pounds. *From 8/20/23 to 9/30/23 he had a weight loss of 8.38% Review of resident 50's EMR revealed that on 9/12/2023 there had been a nutrition note RD D	F 710		

(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 710	Continued From page 34 that revealed: *His diagnoses included: Alzheimer's disease, urinary tract infection, abdominal pain, cystitis, urinary retention, edema, constipation, and dementia. *His medications had included: senna, MiraLAX, and furosemide. *He was on a regular diet and had eaten 50-100% of his meals. *He had eaten his meals in the memory care unit with encouragement and assistance as needed. *He was able to make needs known "at most times". *He had one dish of ice cream daily. *His weight was recorded as 180 pounds. *His body mass index was a score of 29, meaning he was overweight. *History of weights included that he weighed 184 pounds 30 days ago and 203 pounds 90 days ago. -His weight was down 11.4% in 90 days. *He had gained weight in the last year and was coming back down to his usual body weight range. *RD would continue to monitor. *There was no documentation to support his physician had been notified of his weight loss. Interview on 10/05/23 at 3:05 p.m. with CNA I regarding weighing of residents revealed: *They were weighed on their bath days. *That weight was documented in each resident's electronic medical record. *Residents were reweighed on that same day if there was a variance. -When the variance was accurate, she would have notified the nurse. Interview on 10/05/23 at 3:06 p.m. with LPN K	F 710		

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

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 10/06/2023

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 710	Continued From page 35 regarding resident 50's weight loss revealed: *She thought he had lost weight, "Just by looking at him". *His medical record noted that he had lost approximately 20 pounds since April 2023. *His weight since the beginning of August 2023 had varied. *She had not reported his weight loss to anyone. Interview with RD on 10/6/23 at 3:55 p.m. regarding weight loss of resident 50 revealed she: *Was aware resident 50 had a significant weight loss. *Was not concerned about this weight loss as he was overweight. *Had not notified the physician of his weight loss. Review of the provider's undated weight policy revealed: *"A significant weight change report is sent to care conference members and printed to the nurses' stations at least monthly." *"Significant changes are defined as 5% or more in one month and 10% or more in 6 months. 7.5% in 3 months is also considered a significant change, but is not coded on the MDS as such." *"Information is requested from the care conference team regarding possible underlying causes of weight changes as well as possible interventions." *"Interventions may include (but not limited to): -Reweighing the resident. -Interviewing the resident or direct care-givers. -Reviewing the medical records, labs, history. -Referrals to appropriate care team members. -Reviewing food intake records. -Referral to the quality of life committee. -Nutritional supplementation. -Reviewing the care plan."	F 710		

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 10/06/2023

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 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure orientation had been completed for six of six sampled temporary staff, including four certified nursing assistants (CNAs) (O, P, Q, and R) and two	F 726	1. The facility will provide an orientation for agency staff before they are allowed to work their first shift with the facility. 2. Before agency staff members start their first shift, they must review and sign that they have read and understand the orientation paperwork specific to the facility. The facility scheduler and staff development coordinator will communicate when a new agency staff member starts and will supply them with an orientation and tour of facility. Agency staff must sign that they received and understood the information on the orientation process. On annual basis process will be conducted again to ensure proper orientation is completed. Policy reviewed and updated for orientation of agency staff with facility. 3. Education provided by Administrator, DON, and ADON to facility schedular and staff development coordinator on appropriate orientation and required information needs to be signed before agency staff work a scheduled shift. This process will be audited by DON, ADON, and designee twice a week for 3 weeks, then once weekly for 2 months. 4. Results of initial as well as ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for three months.	AOC: 11/2/2023

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 10/06/2023

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 726	Continued From page 37	F 726		

licensed practical nurses (LPNs) (S and T) prior to working directly with residents. Findings include:

1. Observation and interview on 10/3/23 at 10:20 a.m. with LPN M on the third-floor memory care unit regarding staffing revealed the provider used nurses and CNAs from staffing agencies at times to staff five nursing units on the day, evening, and night shifts.

Interview on 10/4/23 at 11:00 a.m. with an anonymous employee from a staffing agency regarding her orientation revealed:
*This was the third shift she had worked the past three days.
*She was oriented to the time keeping system, but had received no formal orientation regarding the care of residents.

Review of the provider's daily nursing schedules from 10/3/23 through 10/6/23 revealed each day's schedule had:
*Two to four CNAs scheduled each day on either the day or evening shifts that included:
-Seven different CNAs.
-Three different staffing agencies.
*One to two LPNs scheduled each day on either the day and/or the evening or the night shift that included:
-Four different LPNs.
-Two different staffing agencies.

Interview on 10/06/23 at 5:46 p.m. with administrator A, director of nursing (DON) B, and assistant DON C revealed:
*The provider utilized CNAs, LPNs, and registered nurses (RNs) from several different staffing agencies on a regular basis that included:

(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 726	Continued From page 38	F 726		

-Short term assignments of 2 to 3 shifts.
-Month-to-month contracts.
-Long-term contracts of three months or longer.
*When discussing how they ensure those staff were competent and had the knowledge and skills necessary to care for the residents:
-Administrator A stated each individual agency staff member was required to wear an identification badge from that agency which displayed a photo, name, and position of that individual.
-Administrator A stated "Our expectation is they are ready to go."
-DON B stated it was the agency employee's responsibility to get the required training to maintain their certification or license.
*In reviewing how the agency staff were provided orientation to the facility DON B revealed each agency staff member was:
-Sent to the nursing unit they were assigned to.
-Introduced to the staff on the unit.
-Given a tour of the unit and floor they were assigned.
-Provided with a one-page "pocket care plan."
*Administrator A and DON B further revealed:
-No individual personnel files were kept for agency staff members.
-No orientation of agency staff was documented or retained.

On 10/6/23 at 10:15 a.m. a request was made to DON B for:
*The policy for agency staff orientation and training.
*Agency personnel files including registry verification and orientation/training for:
-CNAs O, P, Q, and R.
-LPNs S and T.

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 10/06/2023

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 726	Continued From page 39 On 10/06/23 at 5:08 p.m. documentation was received from the provider that included: *A one-page "Registration Verification" for active CNA registration for the following: -CNA O dated 10/2/23. -CNA P dated 10/19/22. -CNA Q dated 10/6/23. -CNA R dated 10/6/23. *A two-page "QuickConfirm License Verification Report" for active LPN licensure for the following: -LPN S dated 9/21/23. -LPN T dated 9/28/23, *LPN T's "Basic Life Support" certification from the American Heart Association. *No other documentation for the above agency staff was provided. *No policy for agency staff orientation/training was provided. Review of the provider's Employee List that included contracted agency staff revealed: *Nine RNs were listed as "Contract" from four staffing agencies, none of whom worked during the time of the survey. *Thirteen LPNS were listed as "Contract" from four staffing agencies and two LPNs S and T were identified and worked during the time of the survey. *Seventy-one CNAs were listed as "Contract" from seven staffing agencies and four CNAs O, P, Q, and R were identified and working during the time of the survey.	F 726		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	1. Review of survey findings on each dishwasher on all three floors and updated dishwasher log sheet.	AOC: 11/2/2023

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 10/06/2023

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 812	Continued From page 40 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (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, record review, interview, and policy review, the provider failed to ensure proper sanitary conditions were followed for 72 of 72 residents who received meals from three of three kitchens; that failure had the potential to affect all 72 residents for foodborne illnesses. Specifically, the provider failed to monitor the temperatures for three of three mechanical dishwashers with incomplete temperature sanitizing logs. Findings include: 1. Observation and interview on 10/3/23 at 8:06 a.m. with food service supervisor E during the initial tour of the first floor main kitchen revealed: *A mechanical dishwasher that used a high temperature sanitizing process. *The August 2023 dishwasher temperature log that had been posted on the wall across from the dishwasher. -That temperature log sheet had mostly blank areas, with very few temperature entries.	F 812	The process is initiated to ensure temperature is appropriately taken. No residents were identified to have adverse reactions from dishwasher temperature documentation. 2. A dishwasher staff member will be responsible for checking the dishwasher's temperature and recording it on the log sheet. The log sheets will be reviewed twice a week to ensure that proper temperatures are being recorded. 3. Education provided by the Administrator, dietary manager and dietician to all dietary staff that dishwasher temps must be taken throughout the day to ensure proper dishware cleaning is completed. The dietician and dietary manager will do audits twice a week for 3 weeks, then once weekly for 2 months. 4. Results of initial as well as ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for three months.	

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 10/06/2023

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 812	Continued From page 41	F 812		

*Food service supervisor E agreed the temperatures had not been consistently taken by the dietary staff.
*There had been a chemical sanitizing dishwasher on both the second and third floors where they had served meals for the residents.
*The dietary department had several open positions.
*They had been actively trying to recruit to fill those positions.
*The facility had offered incentives to dietary staff for open shifts that were available.
*Open shifts had been filled without a problem due to those incentives.

Further review of the August 2023 main kitchen mechanical dishwasher temperature log revealed:
*There were columns for breakfast, lunch, and dinner and also included a column for wash and rinse cycle temperatures.
-The columns for the breakfast and dinner meals were blank.
-There had been eight out of thirty-one entries made for the lunch meal that included the wash and rinse cycle temperatures.
-The bottom of the log sheet had September 2023 with handwritten documented entries for nine out of thirty days for the lunch meals.
*There had not been an October 2023 temperature log sheet posted in the dish room.
*Minimum temperature standards for the wash cycle for the dishes was to have been 150 degrees Fahrenheit (F), and 180 degrees F for the final rinse cycle.
*The above entries had been in the appropriate temperature ranges for that high-heat mechanical dishwasher.
*There had been no temperature log sheets posted for the dietary staff to document for the

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 10/06/2023

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 812	Continued From page 42	F 812		

second and third-floor dishwasher rooms.
*A request was made for the temperature log sheets for the second and third-floor chemical sanitizer dishwashers and no documentation was provided.
-The last temperature logs provided for the second and third-floor chemical sanitized dishwashers was July 2023.

Interview on 10/6/23 at 12:41 p.m. with food service supervisor E revealed:
*She had been the food service supervisor for 4 years, but had been employed by the facility for 22 years.
*She had not completed the required training to become a certified dietary manager.
*She had started the education before but had not been able to continue with it because of staffing issues.
*None of the staff were Serv Safe certified.
*Her Serv Safe certification had expired in February 2023.
*She confirmed the temperature logs for all three of their mechanical dishwashers were not completed consistently according to the policy.
*The lack of documentation surprised her.
*The chemical-sanitized dishwashers were just replaced a few months prior and staff were documenting taking dishwasher temperatures appropriately at that time.
*Blank copies of the temperature log sheets had been available for use in each kitchen and should have been posted by the dietary staff and documented at each mealtime.
*It was her expectation that dietary staff working in the dish rooms would complete the temping of the dishwashers for each meal that was served to the residents.
*She agreed that if dietary staff had not temped

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 10/06/2023

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 812	Continued From page 43 the dishwashers for proper sanitization temperatures, it would have placed all of the residents at risk for foodborne illnesses. Interview on 10/06/23 at 3:20 p.m. with registered dietician D regarding dishwasher machine temping revealed: *The dietary staff were supposed to complete dishwasher temps after breakfast, dinner, and supper meals and record those temperatures on a log sheet posted in the dish rooms. *She agreed that if temping had not been completed, it could have been an infection control concern for all of the residents. Review of the provider's undated Dish Machine Temperature Log Policy and Procedure revealed: *"Policy: Dietary staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. *Procedure: -1. Dietary staff will record dish machine temperatures after breakfast, dinner, and supper meal times in temperature log provided. -2. Dietary staff will make sure dish machine is temping before using. -3. Notify maintenance, [staff name and staff name]. Then [company name who serviced dishwashers and company name who supplied sanitizing chemicals] will be notified. -4. Use of other dish machine will be utilized until correct temps are reached on dish machine."	F 812		
F 880 SS=D	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	F 880	1. Based upon the initial audit, the facility has purchased an appropriate number of slings for each resident who uses a lift to have their own sling.	AOC: 11/2/23

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 10/06/2023

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 880	Continued From page 44 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 §483.70(e) 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: (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	F 880	Equipment used for multiple residents will be wiped down and sanitized before use with another resident. 2. Order received on 11/2/2023. Each resident will keep their sling in their room and be sent to the laundry when visibly soiled. The facility has also purchased single-use and super sanitation wipes that will be supplied to nursing staff for wiping down and cleaning resident equipment. These wipes will be readily available on each unit. 3. With collaboration with QIN in root cause analysis to determine best infection control practices. Infection control preventionists, administrator, DON, and ADON supplied education to nursing staff on the process for proper sanitation of slings and lifts. Infection control prevention, DON, ADON, or designee will be auditing the infection control practice twice a week for 3 weeks, then once weekly for 2 months. Policy and procedure reviewed and updated. Education was provided in nursing staff meetings on 10/26/2023 and 10/27/2023. Education was also sent out through the Paycom online portal on 10/27/2023; this will be how to track education completion. 4. Results of initial as well as ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for three months.	

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 10/06/2023

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 880	Continued From page 45	F 880		

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:
Based on observation, interview, and policy review the provider failed to ensure two of two mechanical lifts and body slings were properly disinfected between resident use on two of two observed occasions.
Findings include:

1. Observation and interview on 10/5/23 at 2:42 p.m. with certified nursing assistant (CNA) I and resident 50 revealed:
*Resident 50 was in his room, sitting in a Broda (specialized wheelchair) chair.
*She transferred resident 50 from his Broda chair to the restroom using a sit-to-stand mechanical lift.

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 10/06/2023

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 880	Continued From page 46 -After he used the restroom, she transferred him back to his Broda chair. --She then removed the sit-to-stand mechanical lift and body sling from the room and placed it in the hallway. -CNA I had not disinfected the mechanical lift or body sling. --She confirmed several residents used the same sit-to-stand mechanical lifts and the same body slings. --She was aware that she was supposed to disinfect the equipment by using Sani-wipes. --She was not aware where those Sani-wipes were kept. --She had only been employed for "about a month". Interview on 10/5/23 at 3:03 p.m. with licensed practical nurse (LPN) K regarding disinfecting of the sit-to stand mechanical lifts and the body slings revealed: *She confirmed several residents used the same sit-to-stand mechanical lifts and the same body slings. -The equipment should have been disinfected after each resident use by using the disinfectant Sani-wipes. *She agreed the body slings were cloth which made them an uncleanable surface. Observation on 10/5/23 3:36 p.m. revealed four sit-to-stand mechanical lifts sitting in the hallway with a transfer body sling draped over each of them. Continued interview on 10/5/23 at 3:38 p.m. with LPN K revealed: *Sani-wipes were stored in the locked medication room.	F 880		

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 10/06/2023

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 880	Continued From page 47	F 880		

-Nurses and medication aides were the only staff who could access them in the locked medication room.
-Sani-wipes used to have been kept on carts in the hallways.
--They had been removed because the residents had taken them and used them as handwipes.
-She confirmed CNA I had not requested Sani-wipes to disinfect the sit-to-stand mechanical lift and the body sling after assisting resident 50.

Interview on 10/6/23 at 4:16 p.m. with director of nursing (DON) B and administrator A regarding the disinfecting of lifts revealed:
*Their process for disinfecting the mechanical lifts and the body slings had been to:
-Use a purple topped container containing Sani-wipes (which is a germicidal wipe) to wipe the equipment down after each resident use.
-Body slings for sit-to-stand mechanical lifts were shared between residents
-When the slings became visibly dirty, they would have been sent to the laundry department to have been washed.
-Harness body slings used with full body mechanical lifts were not shared between residents.
-Sani-wipes were kept in the nurses' carts, dirty utility rooms, locked cupboards, and locked medication rooms on the memory care units.
-They had not known the Sani-wipes were not readily available to the nursing assistants.
-In the past, they had completed audits on the disinfecting of equipment after resident use.
--The last audit had been completed in May 2023 with one staff that was provided "real-time education" for not disinfecting the equipment.
-They had been aware the body slings were

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

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 10/06/2023

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 880	Continued From page 48 shared between residents and would have only washed them when visibly dirty. *DON B agreed not disinfecting shared equipment between resident use was an infection control issue. 2. Observation on 10/5/23 at 4:06 p.m. with CNA V and resident 67 during a transfer revealed: *Resident 67 was in her room sitting in her recliner. *CNA V transferred resident 67 from the recliner to her bed using a sit-to-stand mechanical lift. *She positioned the resident in bed. *CNA V then wheeled the mechanical lift into the hallway next to the wall. *She had not sanitized the mechanical lift. *She returned to the nurse's station. 3. Review of the provider's revised July 2022 Resident Care Equipment and Articles for Handling, Processing and Transport policy revealed: *"Purpose -Reusable equipment is to be cleaned between resident use and reprocessed appropriately...The facility protects indirect transmission through decontamination (i.e., cleaning, sanitizing, or disinfecting of an object to render it safe for handling. *Policy" -"2. The employee should disinfect reusable equipment between resident uses or before transport using a disinfectant."	F 880		

PRINTED: 10/23/2023
FORM APPROVED
OMB NO. 0938-0391

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

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 ______	10/06/2023

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

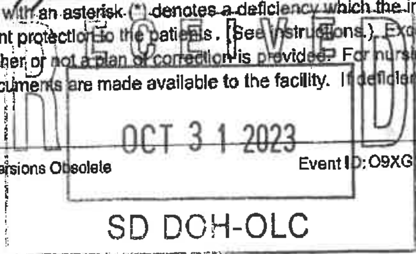
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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 from 10/3/23 through 10/6/23. Jenkin's Living Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kasey Klappmeier

TITLE: President/CEO

(X6) DATE: 10/31/2023

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.



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

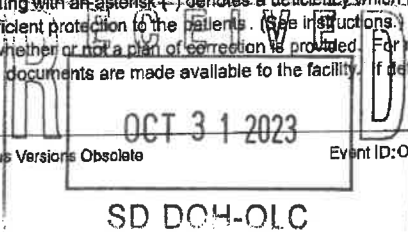
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/03/2023

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/3/23. Jenkin's 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 2012 LSC for Existing Health Care Occupancies and the Fire Safety Evaluation System (FSES) dated 10/3/23 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for the K225 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 225 SS=C	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 REQUIREMENT is not met as evidenced by: Based on observation and record review, the	K 225		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: President/CEO | (X6) DATE: 10/31/23

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.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/03/2023

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
K 225	Continued From page 1 provider failed to provide conforming exit stairs for one of three exits (west stair) that did not have a landing. Findings include: 1. Observation on 10/3/23 at 12:39 p.m. 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 identified in K000.	K 225		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 10/3/23 at 12:15 p.m.	K 712	1. A review of fire drill records showed a nighttime fire drill was not staged in the required time frame. A nighttime fire drill was held on 10/25/2023 at 4:15 a.m. to comply with a missed fire drill. 2. Fire drills will be reviewed monthly, as well as the required shift in the QAPI process. 3. Education supplied to the maintenance director regarding the regulation and timing of fire drills required for the facility. The administrator conducts audits to ensure that the fire drill and shift of fire drill meets requirements monthly for six months. 4. Results of initial as well as ongoing audits will be reviewed monthly via the QAPI process for three months.	5. AOC: 10/25/ 2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 01 - **MAIN BUILDING 01** B. WING ______	10/03/2023

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
K 712	Continued From page 2 revealed there was no documentation of any third shift fire drills for quarter three (July, August, and September) of 2023. Interview with the maintenance director at the time of the record review confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 02 - BUILDING 02 B. WING ______	10/03/2023

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/3/23. Jenkin's 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 2012 LSC for Existing Health Care Occupancies and the Fire Safety Evaluation System (FSES) dated 10/3/23 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for the K225 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 225 SS=C	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 REQUIREMENT is not met as evidenced by: Based on observation and record review, the	K 225		F

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

TITLE President/CEO

(X6) DATE 10/31/23

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 02 - BUILDING 02 B. WING ______	10/03/2023

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
K 225	Continued From page 1 provider failed to ensure conforming exit stairs for two of two stairs (east and west stairs) were not conforming. Findings include: 1. Observation on 10/3/23 at 3:10 p.m. revealed the door swinging into the second-floor west stair enclosure reduced the landing to 21 inches. Observation at 3:24 p.m. on 10/3/23 also revealed the door swinging into the second-floor east stair enclosure reduced the landing to 11 inches. Document review of previous survey data confirmed 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 identified in K000.	K 225		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include:	K 712	1. A review of fire drill records showed a nighttime fire drill was not staged in the required time frame. A nighttime fire drill was held on 10/25/2023 at 4:15 a.m. to comply with a missed fire drill. 2. Fire drills will be reviewed monthly, as well as the required shift in the QAPI process. 3. Education supplied to the maintenance director regarding the regulation and timing of fire drills required for the facility. The administrator conducts audits to ensure that the fire drill and shift of fire drill meets requirements monthly for six months. 4. Results of initial as well as ongoing audits will be reviewed monthly via the QAPI process for three months. 5. AOC: 10/25/2023	5. AOC: 10/25/ 2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 02 - BUILDING 02 B. WING ______	10/03/2023

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
K 712	Continued From page 2 1. Record review on 10/3/23 at 12:15 p.m. revealed there was no documentation of any third shift fire drills for quarter three (July, August, and September) of 2023. Interview with the maintenance director at the time of the record review confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 03 - BUILDING 03 B. WING ______	10/03/2023

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/3/23. Jenkin's Living Center Building 03 was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 10/3/23 at 12:15 p.m. revealed there was no documentation of any third	K 712	1. A review of fire drill records showed a nighttime fire drill was not staged in the required time frame. A nighttime fire drill was held on 10/25/2023 at 4:15 a.m. to comply with a missed fire drill. 2. Fire drills will be reviewed monthly, as well as the required shift in the QAPI process. 3. Education supplied to the maintenance director regarding the regulation and timing of fire drills required for the facility. The administrator conducts audits to ensure that the fire drill and shift of fire drill meets requirements monthly for six months. 4. Results of initial as well as ongoing audits will be reviewed monthly via the QAPI process for three months.	5. AOC: 10/25/ 2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: President/CEO
(X6) DATE: 10/31/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 03 - **BUILDING 03** B. WING ______	**10/03/2023**

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
K 712	Continued From page 1 shift fire drills for quarter three (July, August, and September) of 2023. Interview with the maintenance director at the time of the record review confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 04 - BUILDING 04 B. WING ______	10/03/2023

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/3/23. Jenkin's Living Center Building 04 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 2012 LSC for Existing Health Care Occupancies and the Fire Safety Evaluation System (FSES) dated 10/3/23 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for the K225 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 225 SS=C	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 REQUIREMENT is not met as evidenced by: Based on observation and record review, the	K 225		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: President/CEO (X6) DATE: 10/31/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 04 - BUILDING 04 B. WING	10/03/2023

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
K 225	Continued From page 1 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 on 10/3/23 at 1:38 p.m. 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 identified in K000.	K 225		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include:	K 712	1. A review of fire drill records showed a nighttime fire drill was not staged in the required time frame. A nighttime fire drill was held on 10/25/2023 at 4:15 a.m. to comply with a missed fire drill. 2. Fire drills will be reviewed monthly, as well as the required shift in the QAPI process. 3. Education supplied to the maintenance director regarding the regulation and timing of fire drills required for the facility. The administrator conducts audits to ensure that the fire drill and shift of fire drill meets requirements monthly for six months. 4. Results of initial as well as ongoing audits will be reviewed monthly via the QAPI process for three months.	5. AOC: 10/25/ 2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 04 - BUILDING 04 B. WING ______	10/03/2023

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
K 712	Continued From page 2 1. Record review on 10/3/23 at 12:15 p.m. revealed there was no documentation of any third shift fire drills for quarter three (July, August, and September) of 2023. Interview with the maintenance director at the time of the record review confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 05 - BUILDING 05 B. WING ______	10/03/2023

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/3/23. Jenkin's Living Center Building 05 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 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K222 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	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	K 222	Three total doors affected by the survey review were identified. Initial review locking mechanism disengaged from the inside to enable exit from the inside with pushing door release. Doors are still able to be locked from the outside. 2. Doors in working order and disengaged on 10/31/2023, identified in 2567. Audits will be conducted weekly for two weeks and then monthly for 3 months to ensure doors work correctly. 3. Results of initial as well as ongoing audits will be reviewed monthly via the QAPI process for three months.	4. AOC: 10/31/ 2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: President/CEO
(X6) DATE: 10/31/23

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 05 - BUILDING 05 B. WING	10/03/2023

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
K 222	Continued From page 1 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 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 REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 05 - BUILDING 05 B. WING	10/03/2023

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
K 222	Continued From page 2 provider failed to provide egress doors as required at three randomly observed locations (west resident corridor exit, east resident corridor exit, and east dining exit). Findings include: 1. Observation on 10/3/23 at 12:38 p.m. revealed the exit door at the west end of the resident corridor was equipped with electrical lock hardware that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed the audible signal would sound but would not continue after pressing on the release device for over three seconds. Also, the required irreversible process of unlocking the door did not initiate. 2. Observation on 10/3/23 at 12:48 p.m. revealed the exit door at the east end of the resident corridor was equipped with electrical lock hardware that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed the audible signal would sound but would not continue after pressing on the release device for over three seconds. Also, the required irreversible process of unlocking the door did not initiate. 3. Observation at on 10/3/23 12:58 p.m. revealed the exit door on the east side of the dining area was equipped with electrical lock hardware that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed the audible signal would sound but would not continue after pressing on the release device for over three seconds. Also, the required irreversible process of unlocking the door did not initiate. Interview with the maintenance director at the	K 222		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 05 - BUILDING 05 B. WING ______	10/03/2023

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
K 222	Continued From page 3 same time of the above observations confirmed those conditions. He stated building five had previously been a memory unit with special locking provisions and had only recently changed to a rehab unit. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected one of five exit doors. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 10/3/23 at 12:15 p.m. revealed there was no documentation of any third shift fire drills for quarter three (July, August, and	K 712	1. A review of fire drill records showed a nighttime fire drill was not staged in the required time frame. A nighttime fire drill was held on 10/25/2023 at 4:15 a.m. to comply with a missed fire drill. 2. Fire drills will be reviewed monthly, as well as the required shift in the QAPI process. 3. Education supplied to the maintenance director regarding the regulation and timing of fire drills required for the facility. The administrator conducts audits to ensure that the fire drill and shift of fire drill meets requirements monthly for six months. 4. Results of initial as well as ongoing audits will be reviewed monthly via the QAPI process for three months.	5. AOC: 10/25/2 023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 05 - BUILDING 05 B. WING	10/03/2023

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
K 712	Continued From page 4 September) of 2023. Interview with the maintenance director at the time of the record review confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

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 ______	10/06/2023

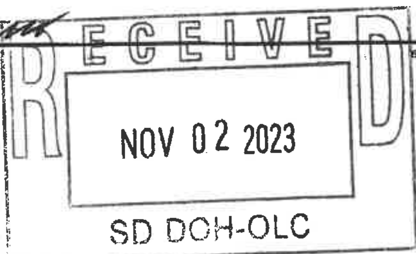
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 S MAPLE ST WATERTOWN, SD 57201

(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 from 10/3/23 through 10/6/23. Jenkin's Living Center was found not in compliance with the following requirements: S294 and S296.	S 000		
S 294	44:73:07:09 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, shall be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or qualified dietitian. Each planned menu shall be approved, signed, and dated by the dietitian for each facility. Any menu changes from month to month shall be reviewed by the dietitian and each menu shall be reviewed and approved by the dietitian at least annually if applicable. Each menu as served shall meet the nutritional needs of the residents in accordance with the physician's, physician assistant's, or nurse practitioner's orders and the Dietary Guidelines for Americans, 2010. A record of each menu as served shall be filed and retained for 30 days. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure the registered dietician (RD) D had reviewed, approved, and signed the menus annually. Findings include: 1. Review of the provider's current menus revealed they had not been approved, signed, or dated by RD D. Interview on 10/6/23 at 12:41 p.m. with food	S 294	1. Written menus reviewed and signature completed on 10/25/2023. 2. The facility's dietician will continuously review menus with the dietary manager and complete the annual signature when required. 3. Education provided by the administrator to a dietician and dietary manager on the regulation that menus will need to be signed on an annual basis and that this will be monitored via the QAPI process. Every six months, the dietician will audit menus to ensure they have been signed at least annually.	4. AOC: 11/2/2023

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

TITLE President / CEO

(X6) DATE 11/2/23



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 ____	10/06/2023

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 294	Continued From page 1 service supervisor E regarding the menus revealed: *RD D had been employed by the facility for several years. *She confirmed RD D had not signed the current menus. *The last documented menus with signatures was April 2019. *They reviewed the menus together on an ongoing basis. *It was a subject she had spoken with RD D but she thought it had fallen through the cracks. Interview on 10/6/23 at 3:20 p.m. with RD D regarding menus revealed: *The food service supervisor reviewed the menus with her. *She confirmed April 2019 had been the last time the menus had been signed by her. *She was unaware the menus were to have been reviewed and signed each year. *She agreed that without the signature there was no documentation to prove the menus had been reviewed and approved.	S 294		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection	S 296	1. Review of survey findings staff members had ServSafe Food Protection Program certificate but had a lapse where it was not renewed for the year 2023. The dietary manager registered for the course on 10/10/203. One of the facility cooks registered for the course on 10/26/2023. Dietician will be proctored and registered for exam on 11/2/2023. 2. The facility's dietician and dietary manager will acquire a ServSafe Food Protection Program certificate to ensure the facility meets state requirements for regulation.	5. AOC: 11/7/2023

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 ______	10/06/2023

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 296	Continued From page 2 Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, and record review, the provider failed to ensure the food service supervisor and a cook possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 10/6/23 at 12:41 p.m. with food service supervisor E revealed: *They had no current staff that were ServSafe certified. *Her certification and one of the cooks expired in February 2023. *They were very busy due to open dietary positions. *She was aware that one cook and the food service supervisor should have a current ServSafe certificate.	S 296	3. Education is given by administrator to dieticians and dietary managers on the requirement for at least one manager and one cook to have the ServSafe Food Protection Program. This certificate is to be renewed annually and ensured that it is kept up to date. The administrator will conduct a monthly audit to ensure proper certification is upheld. 4. Results of initial as well as ongoing audits will be reviewed monthly via the QAPI process for three months.	

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 ____	10/06/2023

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 296	Continued From page 3 Interview on 10/6/23 at 3:20 p.m. with RD D revealed: *She expected food service supervisor E and a cook to have possessed a current ServSafe Food Protection Program certificate. *She agreed they had not followed the regulation.	S 296		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 10/3/23 through 10/6/23. Jenkin's Living Center was found in compliance.	S 000		