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

PRINTED: 10/07/2024 FORM APPROVED OMB NO. 0938-0391

F 000  INITIAL COMMENTS  A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/3/24 through 9/4/24. Areas surveyed included accidents relating to a fall with injuries. Jenkin's Living Center was found to have past noncompliance at F699.  F 689 Free of Accident Hazards/Supervision/Devices SS=D CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(2) Each resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, policy review, and interview the provider failed to ensure the safety of one of one sampled resident (1) who had an unwitnessed fall and required hospitalization for injuries the next day. This citation is considered past non-compliance based on a review of the provider's s/9/24 DOH FRI for resident 1 revealed:  1. Review of provider's 8/9/24 DOH FRI for resident 1 revealed:  1. Review of provider's 8/9/24 DOH FRI for resident 1 revealed:  1. Review of provider's 8/9/24 DOH FRI for resident 1 revealed:  1. His Brief Interview for Mental Status (BIMS) score was 7 which meant he had severe cognitive		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		CONSTRUCTION		X3) DATE SURVEY COMPLETED	
JENKINS LIVING CENTER  (X49) D  SUMMARY STATEMENT OF DEFICIENCIES 125 SOUTH MAPILE STREET WATERTOWN, SD 57201  PREDIX SUMMARY STATEMENT OF DEFICIENCIES 125 SOUTH MAPILE STREET WATERTOWN, SD 57201  FROM INITIAL COMMENTS  A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 973/24 through 94/24. A reas surveyed included accidents relating to a fall with injuries. Jenkin's Living Center was found to have past noncompliance at F689. F689 Free of Accident Hazards/Supervision/Devices SS=D CFR(s) 483.25(d)(1)(2)  \$483.25(d)(1)(2)  \$483.25(d)(2)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This RECUIREMENT is not met as evidenced by. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, policy review, and interview the provider failed to ensure the safety of one of one sampled resident (1) who had an unwitnessed fall and required hospitalization for injuries the next day. This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident. Findings include:  1. Review of provider's 8/9/24 DOH FRI for resident 1 revealed:  "On 8/9/24 at 10.25 p.m. he had an unwitnessed fall. His Brief Interview for Mental Status (BIMS) score was 7 which meant he had severe cognitive			435036	B. WING_			1		
FREEIX TAG  REGULATORY OR ISC IDENTIFYING INFORMATION  FOOD  INITIAL COMMENTS  A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/3/24 through 9/4/24. Areas surveyed included accidents relating to a fall with injuries. Jenkin's Living Center was found to have past noncompliance at F689.  F689 F689 F687 F697 F697 F697 F698 F698 F697 Accident Hazards/Supervision/Devices  CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - \$483.25(d)(1)(2)  §483.25(d)(2)Each resident environment remains as free of accident hazards as is possible; and \$483.25(d)(2)Each resident environment remains as free of both facility must ensure that expervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by.  Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, policy review, and interview the provider failed to ensure the safety of one of one sampled resident (1) who had an unwitnessed fall and required hospitalization for injuries the next day. This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident. Findings include:  1. Review of provider's 8/9/24 DOH FRI for resident 1 revealed:  1. Review of provider's 8/9/24 DOH FRI for resident the provider incident. Findings include:  1. Review of provider's 8/9/24 DOH FRI for resident the provider incident. Findings include:  1. Review of provider's 8/9/24 DOH FRI for resident the provider is 8/9/24 DOH FRI for resident the provider incident. Findings include:  1. Review of provider's 8/9/24 DOH FRI for resident the provider is 8/9/24 DOH FRI for resident the					STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET				
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1. Review of provider's 8/9/24 DOH FRI for resident 1 revealed:  *On 8/8/24 at 10:25 p.m. he had an unwitnessed fallHis Brief Interview for Mental Status (BIMS) score was 7 which meant he had severe cognitive	F 000	INITIAL COMMENTS  A complaint health such CFR Part 483, Subpated Term Care facilities withrough 9/4/24. Areast accidents relating to a Living Center was four noncompliance at F66 Free of Accident Hazar CFR(s): 483.25(d)(1)(s) 483.25(d) Accidents The facility must ensugh 483.25(d)(1) The rest as free of accident has \$483.25(d)(2) Each resupervision and assist accidents. This REQUIREMENT by:  Based on South Dake (SD DOH) facility-repreview, policy review, failed to ensure the safe resident (1) who had a required hospitalization. This citation is consider based on a review of	arvey for compliance with 42 rt B, requirements for Long as conducted from 9/3/24 surveyed included a fall with injuries. Jenkin's and to have past 39.  ards/Supervision/Devices 2)  are that - sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced on the provider and interview the provider afety of one of one sampled an unwitnessed fall and on for injuries the next day, ered past non-compliance the provider's corrective	F		Past noncompliance: no plan of	ΝΈ	DATE	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		1. Review of provider' resident 1 revealed: *On 8/8/24 at 10:25 p fallHis Brief Interview fo score was 7 which me	.m. he had an unwitnessed r Mental Status (BIMS) eant he had severe cognitive						

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.

President / CEO

10/08/2024

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

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		435036	B. WING_			C 09/04/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		03/04/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	floor, lying on his bather it is vital signs were normal limits.  He was able to mote the complained of refloor.  He denied hitting hear in the takes Warfarin.  Neuro checks were completed per the percedures policy.  *After being assiste of right hip pain.  He was given as not medication).  *His physician was hear in the was given as not in the series of the percedure in the percedure in the percedure in the was admitted to the evaluation.  *He was admitted to the evaluation.  A critical Troponin attack).  *He returned to the end of the percedure in the percedu	e middle of his room on the ack.  e taken and were within  ve all extremities.  right knee pain while on the  is head. (blood thinner medication).  e not indicated to be provider's Emergency  d off the floor he complained  eeded acetaminophen (pain  faxed about the fall.  ified of the fall.  a.m. a nurse assessed him  ave fixed pupils, and not acting  en, and his blood pressure  emergency room (ER) for  to the hospital for:  ip.  emorrhage (bleeding in the  level (indicative of a heart  facility on 8/12/24 at 1:20 p.m.  to a hospice program.  as changed to Do Not	F	689			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						c		
		435036	B. WING	_		09/04/2024		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					215 SOUTH MAPLE STREET			
JENKIN'S	LIVING CENTER				WATERTOWN, SD 57201			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	× 	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 689	Continued From page	2	F	389				
	administrator A and d revealed: *Residents were cate past fall history.	irector of nursing B gorized as fall risk based on						
		ents were done for residents						
	*There was no Fall Pobefore 8/14/24.	olicy and Procedures Policy						
	*Per provider's Emergresident hit head Neucompleted.	gency Procedures policy if ro checks would be						
	deficient practice doe on 9/4/24 after record *The provider followe- process and educatio nursing care staff.	d their quality assurance						
	Emergency Procedur Neglect Policy, Report and the new Fall Polic Term Care Facility.	es Policy update, Abuse and ting Requirements Policy cy and Procedures for Long						
	unwitnessed falls.	w to be completed for all ocument in the nurse's notes						
	all residents on 8/12/2 completed upon admi	sments were completed on 24, and they are to be ssion and periodically after a significant change in a						
	-Updating of the resid completed following a -Audits on care plans started and complete							
	and the second	J-						

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A35036  NAME OF PROVIDER OR SUPPLIER  JENKIN'S LIVING CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  215 SOUTH MAPLE STREET  WATERTOWN, SD 57201  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)	OATE SURVEY OMPLETED	l` ′^	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OF DEFICIENCIES OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER  JENKIN'S LIVING CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  215 SOUTH MAPLE STREET  WATERTOWN, SD 57201   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE  OSTO-1202-1202-1202-1202-1202-1202-1202-120	I		92=	42E02G		
JENKIN'S LIVING CENTER  215 SOUTH MAPLE STREET WATERTOWN, SD 57201  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X6) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE  DAT	09/04/2024			435036	DDOV/DED OD GUDDUED	NAME OF D
WATERTOWN, SD 57201  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIATED PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLIATED PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIATED PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE COMPLIATED PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLIATED			1		PROVIDER OR SUPPLIER	NAME OF PI
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIA TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			1		S LIVING CENTER	JENKIN'S
	(X5) COMPLETION DATE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	PREFIX	MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PREFIX
*Record review of other resident falls after 8/8/24 showed they were following their new and updated policies.  *Observations and staff interviews revealed the staff understood the education provided and the revised processes.  Based on the above information, non-compliance at F689 occurred on 8/8/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 9/4/24, the non-compliance is considered past non-compliance.			F 689	er resident falls after 8/8/24 lowing their new and aff interviews revealed the education provided and the information, non-compliance 8/8/24, and based on the ed corrective action for the firmed on 9/4/24, the	*Record review of oth showed they were fol updated policies. *Observations and statements and statements are revised processes.  Based on the above if at F689 occurred on the provider's implements deficient practice con non-compliance is co	F 689