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 01/30/2025

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/28/25 through 1/30/25. Jenkin's Living Center was found not in compliance with the following requirements: F584, F657, F689, F732, F811, F849, F880, and F919. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/28/25 through 1/30/25. Areas surveyed included abuse related to an allegation of resident physical and verbal abuse by a staff member and quality of care related to a medication patch removed from a resident by a staff member prior to the resident's shower. Jenkin's Living Center was found in compliance.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584	1. By 2/21/25, maintenance staff fixed and addressed the environmental issues identified in the 2567 in the resident rooms, common room, and Pine Village memory care unit. 2. On 2/19/2025, the administrator, maintenance director, and environmental service director completed an initial audit of the remainder of the facility's resident rooms and common areas because all residents had the potential to be affected.	2/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kasey Klapprodt
TITLE: President / CEO
(X6) DATE: 2/27/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the provider failed to maintain resident rooms and resident common areas in a clean manner free from strong odors, sticky floors, and damage to the walls and bathroom tiles for at least seven resident rooms, at least one resident common area, and at least one shower and one tub room.
Findings include:

1. Observations on 1/28/25 from 9:53 a.m. to 10:36 a.m. in the Pine Village memory care unit on the second floor revealed:
*In resident room 273:
-There were gouges in the corner with exposed

Provider's Plan of Correction (F 584):

3. The administrator, maintenance director, and environmental service director will complete monthly rounds to monitor environmental issues for resident rooms and common areas. The policy and procedure for maintenance repairs were updated and revised. On 2/18/25, the administrator educated the maintenance and environmental service directors on the new process and procedure. When a room change occurs, the maintenance team will repair or paint any damage before the new resident moves into the room. The monthly rounding will identify any home-like issues. Education is provided by the administrator and DON on 2/18/2025 to nursing staff, dietary staff, activities, and housekeeping staff about identifying and reporting concerns to the maintenance team. Education is provided through in-service training and the Paycom portal platform regarding reporting any environmental concerns. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal. The administrator will complete audits weekly for three weeks to identify and address environmental problems.
4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.

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F 584	Continued From page 2 drywall. -Phone cords were in a tangled pile on the floor behind the resident's rocking chair. *In resident room 274: -There were at least five vertical gouges in the wall behind the tan recliner, ranging from approximately two to six inches in size. *In resident room 278: -Drywall was exposed on the out-jutting corner. -Painter's tape had been left on the baseboard. -The wall next to the bed had at least eight quarter-sized gouges, with drywall exposed. -The wall behind the light brown recliner had a gouge approximately two inches by one inch in size with exposed drywall. -There was a scrape approximately six inches above the baseboard that extended about three feet along another wall with exposed drywall. -The bathroom floor was sticky and had a strong urine odor. *In resident room 280: -There was exposed drywall near the baseboard in a corner. *In resident room 284: -The bathroom sink was leaking a steady flow of water, even though the faucet paddles were in the "off" position. *In resident room 286: -The wall behind the bed had vertical gouges with drywall exposed. -There was a gouge on a corner of a wall with exposed drywall. -The hand sanitizer dispenser was not functioning. *In the resident day room: -At least five gouges were in the walls behind the recliners. * The above conditions remained unchanged during additional observations on 1/29/25 from	F 584		

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9:33 a.m. to 10:05 a.m., and on 1/30/25 at 9:05 a.m.

2. Observations on 1/29/25 at 2:21 p.m. and on 1/30/25 at 7:59 a.m. in the North Oak care unit on the third floor revealed:
*In resident room 305:
-A corner of wall tile in the bathroom was chipped and had jagged edges with exposed cement.
-There was a missing piece of tile located just outside the doorway to the left of the sink.
-The hand sanitizer dispenser was not functioning.
*Outside the doorway of resident room 301:
-There were three small gouges in the wall above the railing with exposed drywall.
-There was an approximate two-foot scrape on the wall below the railing with exposed drywall.

3. Interview on 1/30/25 at 3:12 p.m. with activity aide Z about what staff would do if something was not working or needed repair revealed she stated, "I would have to ask the nurse to verify or go to maintenance."

4. Interview on 1/30/25 at 3:19 p.m. with CNA W about what staff would do if something was not working or needed repair revealed she stated, "I would call maintenance for a repair because its faster, but we can use a maintenance green slip and send that to maintenance."

5. Interview 1/30/25 at 3:27 p.m. with LPN R about what staff would do if something was not working or needed repair revealed he stated, "I would call maintenance or use a maintenance green slip."

6. Interview on 1/30/25 at 5:19 p.m. with

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F 584	Continued From page 4 administrator A revealed: *He explained there was no policy for submitting maintenance requests. *He expected staff to submit a green maintenance request slip, talk with someone from the maintenance department directly, or call immediate maintenance requests over the radio.	F 584		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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	F 657	1. Residents 19, 6, 7, 15, 19, 41, 25, 62, 66, 68, 40, 45, 70, and 10 from identified care plan issues have been updated and resolved by 2/19/2025. The care plans have been updated to show hospice services, residents needing assistance, monitoring for medication received, and required placement in a secure unit. The care plans reflect the up-to-date care provided to the residents identified. 2. An initial audit was completed to review all resident care plans to ensure the identified areas above have been documented and are up to date for all residents in the facility's plan of care as of 2/21/2025. 3. Education provided by the DON or designee to ADON, MDS, Dietician, dietary manager, IPC, memory care unit manager, wound nurse, social services, activities, and admission coordinator who are responsible for monitoring and tracking resident care plans is current on 2/19/25.	2/21/2025

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F 657	Continued From page 5 by: Based on observation, interview, record review, and policy review the provider failed to ensure resident care plans had been revised to reflect their current needs for: A. One of one sampled resident (19) who received hospice services. B. Five of five residents (6, 7,15, 19, and 41) who received a pureed diet and were included in the paid feeding assistants program. C. Five of five sampled residents (6, 25, 62, 66, and 68) who required transmission-based precautions (TBP). D. Three of three sampled residents (40, 45, and 70) who required monitoring for medications they received. E. One of one sampled resident (10) who required placement on a secure memory unit. Findings include: A. 1. Interview on 1/29/25 at 11:34 a.m. with licensed practical nurse (LPN) L regarding resident 19 revealed resident 19 had gallstones, no surgery was recommended, and she began receiving hospice services about two weeks ago. 2. Interview on 1/30/25 at 8:52 a.m. certified nursing assistant (CNA) FF regarding identifying residents who received hospice services revealed: *She identified resident 19 received hospice services. *That information was provided to her by the nurse, and it would be on the "pocket" care plan. *Hospice visited resident 19 one to two times a week to take her vitals and provide a bed bath. 3. Review of the provided pocket care plan did	F 657	Care plans will be reviewed promptly, and significant changes warrant updating the care plan. A weekly meeting will be held to review care plans, and specific responsibilities will be reviewed to ensure that all parts of the care plan are created and updated appropriately. The DON or designee will conduct audits once a week for 3 weeks and then monthly for two months. Policy and procedure for care plans were reviewed and revised. 4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

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not indicate that the resident received hospice services.

4. Review of resident 19's care plan revealed:
*She admitted to the facility on 4/26/18.
*Her diagnoses included mild intellectual disabilities, osteoarthritis, anemia, heart failure, fracture of left patella (kneecap), acute kidney failure, anorexia, and anxiety disorder.
*A nutrition focus area indicated, "Currently on hospice" was revised on 1/28/25.
*The nutrition goal indicated, "Comfort Care Nutrition provided due to hospice."
*The nutrition interventions included, "1/28/24: Admitted to hospice on 1/17 [2025] due to recent diagnosis of Calculus of Gallbladder with Acute Cholylith [Cholelith, gallstones] with back pain. General surgeon recommends comfort cares over surgical intervention."
*There were no other focus areas, goals or interventions related to resident 19's hospice care.

5. Interview on 1/30/25 at 4:19 p.m. with administrator A and director of nursing (DON) B regarding resident 19's hospice care revealed:
*There had been a delay in getting the hospice admitting diagnosis for resident 19.
*She was admitted to hospice on 1/17/25.
*During the interview DON B called the hospice provider to request a copy of the physician's order and the hospice care plan.
*DON B stated she updated the facility care plan to reflect that resident 19 had been admitted to hospice and the services she received.
*She expected the care plan to reflect the specific care resident 19 received.

6. Review of resident 19's 1/30/25 updated care

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F 657	Continued From page 7 plan revealed: *Her care plan included a focus area, "See the MAR/TAR [medication administration record/treatment administration record], Physician orders/protocol, CNA flow sheets and the Short Term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment in integrated therapy reports if applicable. Care plans are written by the exception reflecting facility standards. Administer medications as ordered. [Resident 19] was admitted to Hospice on 1/17/25" revised on 1/30/25. *There was no resident-centered goal, it directed to "See Focus" revised on 4/16/24. *There were no specific interventions, it directed to "See Focus" initiated on 5/9/18. B. 1. Observation and interview on 1/28/25 between 11:42 a.m. and 12:08 a.m. with cosmetologist AA in the Dixie dining room revealed: *Cosmetologist AA assisted resident 19 in eating with a spoon and assisted her in drinking from a cup with two handles and a lid. *Cosmetologist AA was trained as a hair stylist, certified to assist in the kitchen, and had completed a training program for paid feeding assistants. She was not a certified nursing assistant (CNA). 2. Observation and interview on 1/29/25 at 11:48 a.m. in the Dixie dining room revealed: *Resident 19 was assisted in eating a pureed meal by cosmetologist AA. *Resident 41 was assisted in eating a pureed meal by activities aide (AA) Y. -AA Y confirmed she worked in the activities department, was a paid feeding assistant and not a CNA.	F 657		

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3. Interview on 1/29/25 between 12:21 p.m. and 12:35 p.m. with staff development coordinator (SDC) H and speech therapist (ST) G regarding the paid feeding assistant program revealed:
*SDC H was new in the role of staff development coordinator and oversaw the paid feeding assistant program since August 2024.
*ST G stated that she determined which residents could be assisted by paid feeding assistants.
*Participation in the feeding assistant program was made by the interdisciplinary team based on ST G's recommendation and it was care planned.

4. Review of the provider's 1/27/25 Feeding Assistant List revealed:
*Sixteen residents were participating in the Feeding Assistant program.
*Six of those residents (6, 7,15, 19, and 41) received a pureed diet.
*There were no residents listed under the "Requiring CNA's [CNAs] to Feed."

5. Review of resident 6's electronic medical record (EMR) revealed:
*She received a pureed diet.
*Her care plan indicated on 5/29/24 that she, "did agree to a pureed texture for her foods. Daughter states [resident 6] can't chew the chopped-up food even now."
*She "does have swallowing problems occasionally."
*She was screened by speech therapy in April 2024 twice for "swallowing concerns."
*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.

6. Review of resident 7's EMR revealed:

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*She received a pureed diet.
*Her care plan revealed, "Nutrition risks include: cognition, dysphagia [difficulty swallowing]."
*"Dependent assist of 1 [one] for eating."
*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.

7. Review of resident 15's EMR revealed:
*She received a pureed diet.
*Her care plan revealed, "Nutrition Risk factors include: cerebral
Infarction [a stroke], dementia, hemiplegia [paralysis of one side of the body], dyshagia [dysphagia, difficulty swallowing]."
*It was documented that she had "some difficulties with eating when her dentures are in."
*A care plan intervention included "Monitor/document ability to chew and swallow."
*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.

8. Review of resident 19's EMR revealed:
*She received a pureed diet.
*A 1/24/25 speech therapy screen indicated a referral was made due to the resident was "pocketing solids [solid foods]."
*A 1/28/25 progress note indicated the feeding assistant reported "patient was a little "gaggy" this morning."
*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.

9. Review of resident 41's EMR revealed:
*She received a pureed diet.
*She had a diagnosis of dysphagia.
*There was no documentation in the care plan

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that indicated that she was assisted by a paid feeding assistant.

10. Interview on 1/30/25 at 8:43 a.m. with AA EE revealed:
*She was an activities assistant and had completed the paid feeding assistant training.
*She assisted residents with eating about once a month.
*She was allowed to assist any resident who needed assistance with eating.
*No one told her which residents to assist with eating.

11. Interview on 1/30/25 at 4:41 p.m. administrator A, DON B, and SDC H regarding the paid feeding assistant program revealed:
*The "Feeding Assistant List" that was provided included all the residents within the facility who required assistance with eating.
*SDC H stated that paid feeding assistants were able to assist any resident not deemed by the speech therapist, to need assistance from a CNA.
*Administrator A stated that a feeding assistant could assist any resident in the facility except those who have been excluded.
*At that time there were no residents who should have been excluded.
*DON B stated care plans did not indicate which residents were in the paid feeding assistant program because it could change.
-The care plans may include if they could not be fed by a feeding assistant, but because there was not anyone excluded, no care plans contained that information.

C.
1. Observation and interview on 1/28/25 at 2:47 p.m. with resident 25 revealed:

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*There was a stop sign on her door and a cart outside that room contained gowns and gloves.
*She wore a boot on her left foot from a recent surgery on her toe.

Observation on 1/30/25 at 8:03 a.m. with resident 25 revealed:
*There had not been any signage on her door that indicated she was on enhanced barrier precautions (EBP).
*She stated she had one toe with a wound and a dressing on it, but the nurse had not looked at it today (1/30/25).
*She stated that staff had worn gloves but not gowns when they assisted her.

Interview on 1/30/25 at 2:21 p.m. with wound care nurse (WCN) I and infection preventionist (IP) C who participated by phone revealed:
*Resident 25 had an open wound to her left toe.
*WCN I was unsure if resident 25 was on EBP for wound care and stated she would need to consult with the infection preventionist.
*WCN I called IP C at home to join the interview.
*IP C stated she had removed resident 25 from EBP because she did not think a Band-Aid was a dressing that required EBP.
*WCN I confirmed that resident 25 had an open wound on her left toe with a Medihoney (wound healing) dressing.
*IPC stated, "I would put her back on EBP with that information."

Review of resident 25's EMR revealed:
*A 1/24/25 weekly wound observation tool indicated resident 25 had a four millimeter (mm) by four mm unstageable wound to her left second toe with an undeterminable depth.
*There was no documentation in the care plan

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that indicated that resident 25 required EBP.

2. Observation on 1/28/25 at 11:12 a.m. with resident 62 and certified nursing assistant (CNA) X revealed:
*There were two signs on her door and a cart outside that room that contained gowns and gloves.
*One sign indicated, "STOP please see nurse," and the other indicated, "Steps to put on PPE 1. Put on Gown and tie 2. Put on gloves."

Interview on 1/30/25 at 7:49 a.m. with WCN I revealed resident 62 was on EBP for a foot wound.

Interview on 1/30/25 at 8:10 a.m. with CNA U revealed:
*The sign on resident 62's door indicated that staff needed to wear a gown and gloves when providing direct care, but it was okay to go in to talk to her or deliver items to her room.
*Resident 62 had an infection in her leg.
*There would be a sign on the resident's door, and she used a pocket care plan to know which residents required staff to wear gowns and gloves when providing their direct care.
*She stated that information was also in the residents' care plans in the EMR.

Interview on 1/30/25 between 8:31 a.m. and 8:40 a.m. with LPN M and WCN I revealed:
*LPN M stated resident 62 was on EBP for a heel wound and staff were to wear a gown and gloves when providing her direct care.
*LPN M expected the CNAs to find information on which residents required EBP on the pocket care plan.
*WCN I stated that the EBP list had been updated

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yesterday (1/29/25) and that residents with wounds and catheters.

The provided pocket care plan did not indicate that resident 62 required EBP.

Review of resident 62's EMR revealed:
*She was admitted on 10/1/24 with a diabetic ulcer (wound) on her right foot.
*Her care plan indicated "hx [history] of MRSA [methicillin-resistant Staphylococcus aureus]" from the wound on her right foot.
*The care plan indicated, "CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag
tightly before taking to laundry."
*There was no documentation in the care plan that indicated the staff were to use a gown or gloves with resident contact.

A review of resident 62's printed medical record documents requested revealed a 10/2/24 physician's order for "Contact precautions: May leave room for meals and therapy as long as wound is covered and not draining. Resident must wash hands with soap and water prior to leaving."

3. Interview on 1/28/25 at 9:53 a.m. with CNA V revealed:
*The signs posted on the residents' doorways by their name badges with a "stop sign" indicated they were on EBP.

Observation on 1/28/25 at 2:29 p.m. outside of resident 68's room revealed:
*There was a sign posted outside of her door that

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stated, "STOP, check with nurse before entering" and signs that indicated the correct way to put on personal protective equipment (PPE).
*There was an empty three-drawer bin in the hallway by her doorway, and a tub that contained a clear trash bag of yellow gowns beside it.

Review of resident 68's EMR revealed:
*She was admitted on 12/20/24.
*She had a Brief Interview for Mental Status (BIMS) assessment score of 12, which indicated she had moderate cognitive impairment.
*Her diagnoses included extended spectrum beta lactamase (ESBL, enzymes that breakdown some antibiotics) resistance.
*A 12/20/24 active contact precaution order.
*An order to clean her arterial ulcers on her right lower extremity (RLE) daily with soap and water and to cover them with an appropriate dressing.
*There was no documentation that indicated she was on contact precaution or EBP in her care plan.

4. Observation and Interview on 1/28/25 at 3:02 p.m. of resident 6 in her room revealed:
*There was a sign with a "stop sign" on it next to her name badge outside of her room.
*There was a three-drawer bin with PPE supplies in it outside of her room.
*She was lying in bed, with a pillow propped under her left side, and a call light button on the moveable tray table in front of her.
*She stated she had a sore on her coccyx, but staff had told her it was healing.
*Staff changed the pressure ulcer (PU) dressing every day.

Review of resident 6's EMR revealed:
*She was admitted on 1/3/2018.

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*She had a BIMS assessment score of 14 which indicated she was cognitively intact.
*She had an order for a wound dressing change daily and as needed that began on 12/6/24 for her PU.
*There was no documentation that indicated she was on EBP in her care plan.

5. Observation on 1/30/25 at 7:56 a.m. of resident 66's room revealed:
*There was no PPE inside or outside of her room.
*There was a sign by the resident's name badge on her door with a "stop sign" on it.

Review of resident 66's EMR revealed:
*She was admitted on 11/20/24.
*She had an active order for wound care related to her PU that began on 1/13/25.
*There was no documentation that indicated she was on EBP in her care plan.

D.
1. Observation on 1/28/25 at 4:09 p.m. of resident 70 revealed she was in her room lying on her bed's alternating air mattress and appeared comfortable with no facial indicators of pain.

Review of resident 70's EMR revealed:
*She admitted to the facility on 12/26/24.
*Her BIMS was scored at 4 indicating severe cognitive impairment.
*She had an Alzheimer's Disease diagnosis.
*Her medications included:
-An antipsychotic medication "QUEtiapine Fumarate [antipsychotic] Oral Tablet":
--"25 MG [milligrams] (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for hallucinations."
--"25 MG (Quetiapine Fumarate) Give 12.5 mg by

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mouth at bedtime for hallucinations."
-Two controlled (medications with risk for abuse of addiction) pain medications:
--"oxyCODONE-Acetaminophen Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 1 tablet by mouth every 12 hours as needed for pain control."
--"fentaNYL Transdermal Patch 72 Hour 12 MCG/HR [mg per hour] (Fentanyl) Apply 1 patch transdermally every 72 hours for Pain and remove per schedule."
-A hypnotic medication "Zolpidem Tartrate Oral Tablet 10 MG (Zolpidem Tartrate) Give 1 tablet by mouth at bedtime for Insomnia."

Review of resident 70's current care plan printed on 1/30/25 revealed:
*Her care plan did not address her antipsychotic, opioid (pain), and hypnotic medications.
*Her care plan included a focus area that was initiated on 1/8/25 "See the MAR/TAR, Physician orders/protocol, pocket care plan and the Long-term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment in integrated therapy reports if applicable. Care plans are written by the direction of the resident and their wishes for their plan of care. Administer medications as ordered.
*There was no resident centered goal, it directed to "See Focus" initiated on 1/8/25.
*There were no specific interventions, it directed to "See Focus" initiated on 1/8/25.
*The focus area regarding her medications did not include:
-A goal regarding her high-risk medications.
-Specific interventions including the medications' side effects that assisted her to meet that goal.

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F 657	Continued From page 17 2. Review of resident 40's current care plan revealed: *A focus area: "See the MAR/TAR, Physician orders/protocol, pocket care plans and the Long Term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment if applicable. Care plans are written by exception reflecting facility standards. Administer medications as ordered." Initiated on 2/25/19. Revised on 4/25/24. -Goal: "See Focus." Initiated on 2/25/19. Revised on 10/29/23. -Interventions: "See Focus." Initiated on 2/25/19. *There were two separate focus areas relating to altered skin integrity due to incontinence. The interventions on one of those focus areas had not been updated since 5/13/21. *There were several "interventions" in other focus areas that appeared to be a copy/paste and summaries of progress notes from the resident's electronic medical record. -For example, there was an "intervention" under the skin focus area that read: --"4/3/24: Interventions were assessed at a skin meeting. The care plan interventions were reviewed and interventions at the time were appropriate - will keep in place. --5/7/24: Interventions were assessed at a skin meeting. The care plan interventions were reviewed and interventions revised. --6/18/24: Interventions were assessed at a skin meeting. The care plan interventions were reviewed and interventions revised. --8/6/24: Interventions were assessed at a skin meeting. The care plan interventions were reviewed and interventions at the time were appropriate - will keep in place." --Initiated on 8/19/24, revised on 8/19/24. *A focus area related to a diagnosis of depression	F 657		

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was initiated on 12/8/24.
-An intervention was added on 12/8/24 that read, "Administer medications as ordered. Monitor/document for side effects and effectiveness."
-Review of resident 40's medication administration records from July 2024 through January 2025 revealed she had not taken any type of antidepressant or mood-altering medication.
*A focus area related to pain was initiated on 7/30/20 and revised on 4/3/24. "[Resident 40] has a history of taking scheduled analgesic [a category of pain-relieving medications]. Staff will monitor for s/s of generalized pain and stiffness."
-An intervention was added on 2/25/19 related to pain that read, "Administer analgesia as per ordered."
-Review of resident 40's medication administration records from July 2024 through January 2025 revealed she had not taken any type of analgesic medication.

Interview on 1/30/25 at 5:19 p.m. with administrator A and DON B revealed:
*They tried to rework their resident care plan policy because of the previous recertification survey.
*DON B was not aware that the interventions for depression and pain medications were still included on resident 40's care plan.
*The nurse manager for the memory care units was responsible for those residents' care plans.
*They had no explanation as to why the resident care plans included goals and interventions of "See Focus."

3. Interview on 1/28/25 at 10:53 a.m. with resident 45 revealed that she thought she was on an

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antibiotic but did not know if she took an anticoagulant (a blood thinner).

Review of resident 45's EMR revealed:
*She was admitted to the facility on 7/25/24.
*Her BIMS assessment score was 14, which indicated she was cognitively intact.
*She had a diagnosis of long-term (current use) of anticoagulants.
*Her medications included "Eliquis [an anticoagulant] Oral Tablet 2.5 MG [milligrams] (Apixaban) Give 2.5 mg by mouth two times a day for atrial fibrillation."

Review of resident 45's current care plan printed on 1/30/25 revealed:
*Her care plan did not address her use of anticoagulant medications.
*Her care plan included a focus area that was revised on 8/7/24, "See the MAR/TAR, Physician orders/protocol, CNA flow sheets and the Short Term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment in integrated therapy reports if applicable. Care plans are written by the exception reflecting facility standards. Administer medications as ordered.
*There was no resident-centered goal; it directed to "See Focus," revised on 8/15/24.
*There were no specific interventions; it directed to "See Focus," revised on 7/25/24.

E.
1. Observation and interview on 1/28/25 at 5:05 p.m. with resident 10 revealed:
*She was in her room sitting in her recliner working on a word puzzle.
*She stated she was living at the facility because the "doctor thought I needed more help."

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Review of resident 10's EMR revealed:
*She had lived at the facility in the secure memory care unit since 7/31/24.
*Her BIMS assessment score was 15 which indicated she was cognitively intact.
*A 7/31/24 admission progress note stated "... it was determined that she was unable to safely return to her own apartment d/t [due to] altered mental... Resident admitted to secured unit d/t [due to] dx [diagnosis] of dementia and history of wandering... in her own apartment building. Secured unit assessment initiated."
*An 8/8/24 physician order summary stated "Resident noted to have a diagnosis of Dementia, because of this condition the resident benefits from the consistent smaller therapeutic environment and the specialized care provided in a secured unit. Specific clinical indications will be reviewed by the interdisciplinary team on a quarterly and as needed basis and documented in the resident's care plan."
*A 9/27/24 social service note stated "She repeatedly commented on wanting to get some things from her old apartment, however she has been informed many times that it's been cleaned out by family/responsible party and her things donated. She was asked before things were dispersed what she wanted. She commented on "hating it here" and voiced confidently that she does not think she needs to be here. Doctor has documented her need for SNF [Skilled Nursing Facility] care. With her comments, she was asked about talking to someone about return to community and her response was "well, if I can get outta here..." Call placed to [first name], LTCO [long term care ombudsman]. Message left..."

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F 657	Continued From page 21 Review of resident 10's current care plan printed on 1/29/25 revealed: *A focus area initiated on 8/8/24 indicated "Resident noted to have a dx of Dementia, this resident benefits from the consistent smaller therapeutic environment and the specialized care provided in a secured unit." *There was no resident-centered goal, only the words "see focus" that was initiated on 8/8/24. *There were no specific interventions, only two narratives in the section for the interventions: -"1/9/25 - [resident 10] she has been noted to have the following symptoms/behaviors: rejection of cares and disorientation to time. Resident's POA [power of attorney] notes that resident has intermittent periods of increased confusion. BIMS assessment completed on 1/8/25 with result of 14.0. Secured unit order received from PCP [primary care physician] on 8/7/24. [First name of resident] does not appear to be impacted by residing in a secured unit. Writer discussed secured unit placement with POA [first name] on 1/7/25, [POA's name] in agreement to with secured unit placement. [Resident 10] has been noted to benefit from the following services provided in the secure unit: specialized care, increased security to allow for independent mobility, smaller/calming environment, therapeutic activities, and consistency. Due to above information, resident will continue secured unit placement. -"[Resident 10] can become very agitated and often yells/swears at staff, typically related to missing her old apartment at [Name of apartment building]. She seems to calm some when staff listen quietly and redirect her towards positive aspects. *The focus area regarding her placement on the secured memory care unit did not include:	F 657		

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F 657	Continued From page 22 -A goal regarding her placement and adjustment to living on the secure memory unit. -Specific interventions to assist her to adjust to living on the unit. Review of the provider's revised August 2024 Care Plan, Resident-Centered and Individualized Plan of Care Policy revealed: *"To ensure that each resident receives individualized, comprehensive, and person-centered care by developing and maintaining a written care plan based on their needs, preferences, and medical conditions." *"Care plans should include a focus, goals and interventions for the resident." *"The resident's care plan is reviewed and/or revised frequently due to changes and updates to the plan of care." *"Each discipline is responsible for updating the care plan as changes to the plan of care occur." *" The care plan covers focuses related to but not limited to: -Medications -Infections -Pressure injuries -Continents and Incontinence of resident -Bowel function of the resident -Fall risk and history -Dehydration and Risk of dehydration -Day-to-day activities and the assistance needed -Activities the resident enjoys doing."	F 657		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689	1. On 2/17/2025, residents 7, 9, 15, 23, 36, 38, 40, 44, 46, and 69 had the identified products in a bin and placed them out of reach in their closets. The identified residents have not had any adverse incidents since they have had the products in their rooms.	2/21/2025

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§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 observation, interview, and record review, the provider failed to properly store products determined to be unsafe for cognitively impaired residents for at least 10 residents (7, 9, 15, 23, 36, 38, 40, 44, 46, and 69) on one of two memory care units.
Findings Include:

1. Observations on 1/28/25 at 10:25 a.m. in resident 36's room revealed:
*There was a sign posted on the mirror in the bathroom that read, "Any product with 'Keep Out of Reach of Children' printed on its label needs to be kept on a closet shelf, i.e.. alcohol, mouthwash, Sween 24 [a moisturizing body cream], Baza Cleanse [a no-rinse lotion], deodorant, etc. Thanks!"
-Mouth Rinse, deodorant, and toothpaste were stored on a shelf in the bathroom and were accessible to the resident.
*CPAP (continuous positive airway pressure) cleaning wipes were stored on top of the resident's dresser and accessible to the resident.
-The container label read "Keep out of reach of children."

2. Interview on 1/28/25 at 3:03 p.m. with resident 36 revealed she was pleasantly confused and was not oriented to place or situation, meaning she did not understand where she was or that she was a resident in a nursing home.

3. Interview on 1/30/25 at 9:46 a.m. with licensed

F 689

2. An initial audit was conducted on 2/17/2025 to determine whether any products that should be out of reach are put into the bin in the resident closet for the remainder of the memory care unit residents.
3. Education provided to all nursing staff through DON or designee in an in-person meeting on 2/18/2025. Education was also sent through the Paycom online portal on 1/18/2025. Education covers identified items that need to be kept out of the residents' reach and kept when not in use in a designated bin in the resident's closet. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in the Paycom Portal. The memory care manager will conduct audits twice weekly for three weeks, then monthly for two months. Policy and procedure reviewed and revised.
4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.

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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 689	Continued From page 24	F 689		

practical nurse (LPN)/Nurse Manager J revealed:
*The signs posted in the resident rooms were for the confused residents or for those who could not perform personal cares on their own.
*The signs were placed in all resident rooms in the memory care units.
*Products with the label "Keep out of reach of children" should have been stored away from the resident, such as the top shelf of a resident's closet, so the resident did not have access to those products.

4. Observation on 1/30/25 at 9:55 a.m. in resident 36's room revealed the CPAP cleaning wipes were still accessible on top of the dresser, and the mouthwash and toothpaste were still accessible on the shelf in the resident's bathroom.

5. Interview on 1/30/25 at 3:19 p.m. with certified nurse assistant (CNA) W revealed:
*When asked how staff determined which residents on the secured memory care units should have their personal care products stored out-of-reach, she explained if a resident had dementia their products should be placed on the top shelf of their closet."
-She was not aware of a policy or process to verify this practice.

6. Interview on 1/30/25 at 3:27 p.m. with LPN R revealed:
*Residents were screened upon admission to the memory care unit to determine if they should have their products stored out-of-reach, when labeled with "Keep out of reach of children."
-Staff were to monitor for resident safety throughout each day.
*If there were changes in the resident's behavior

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F 689	Continued From page 25 or cognition, staff were to report those changes to the nurse managers. -He was not aware of a process for determining which residents could have products accessible and which should have been placed on the top shelf of the closet. 7. Observation on 1/30/25 from 3:12 p.m. to 3:48 p.m. of the Pine Village memory care unit on the second floor revealed: *In resident rooms for residents 7, 9, 15, 23, 38, 40, 44, 46, and 69: -Products labeled "Keep Out of Reach of Children" were in various areas of each resident's rooms and accessible to those residents. -Products identified: mouth rinse, deodorant, Baza All-In-One Perineal Lotion, Gold Bond powder, toothpaste, Biotene mouth spray, perfume, and Head and Shoulders shampoo. 8. Review of resident 36's electronic medical record (EMR) revealed: *She was admitted on 10/28/24. -The most current Minimum Data Set (MDS) dated 11/3/24 indicated a Brief Interview for Mental Status (BIMS) assessment score of 4, which indicated she had severe cognitive impairment. *Diagnoses included unspecified dementia, adjustment disorder with depressed mood, and unspecified mood (affective) disorder. *Her care plan included the following: -She required staff supervision with personal hygiene tasks like oral cares. -She had impaired decision-making skills, impaired memory, impaired cognitive function and thought processes related to her dementia diagnosis. *Her care plan did not include that she required	F 689		

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personal care products like toothpaste, mouthwash, and lotion to be stored out of reach due to her cognitive impairment.

9. Review of resident 7's EMR revealed:
*She was admitted on 12/26/18.
*Her quarterly MDS assessment dated 12/24/24 included the following:
-Under section C for cognitive patterns, the Staff Assessment for Cognitive Patterns was utilized rather than the BIMS assessment.
--She had short-term and long-term memory issues.
--She was able to recall staff names and faces.
--Her daily decision-making skills were severely impaired.
-She had the following diagnoses marked under section I: Non-traumatic brain dysfunction, Alzheimer's disease, dementia, anxiety disorder, depression, and manic depression.

10. Review of resident 9's EMR revealed:
*He was admitted on 11/15/23.
*His quarterly MDS assessment dated 1/21/25 included the following:
- Under section C for cognitive patterns, the Staff Assessment for Cognitive Patterns was utilized rather than the BIMS assessment.
-He had short-term and long-term memory issues.
-He was able to recall staff names and faces.
-His daily decision-making skills were impaired.
-He had the following diagnoses marked under section I: Dementia, Parkinson's disease, anxiety, and depression.

11. Review of resident 15's EMR revealed:
*She was admitted on 8/12/20.
*Her quarterly MDS assessment dated 11/26/24

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F 689	Continued From page 27	F 689		

included the following:
- She had a BIMS assessment score of 7, which indicated she had severe cognitive impairment.
-She had short-term and long-term memory issues.
-She was unable to recall year, month or day.
-Her daily decision-making skills were impaired.
-She had the following diagnoses marked under section I: Dementia.

12. Review of resident 23's EMR revealed:
*She was admitted on 12/22/20
*Her quarterly MDS assessment dated 1/14/25 included the following:
- She had a BIMS assessment score of 4, which indicated she had severe cognitive impairment.
-She had short-term and long-term memory issues.
-Her daily decision-making skills were moderately impaired.
-She had the following diagnoses marked under section I: Alzheimer's disease, dementia, anxiety, and depression.

13. Review of resident 38's EMR revealed:
*She was admitted on 4/29/22.
*Her significant change MDS assessment dated 12/16/24 included the following:
-She had a BIMS assessment score of 11, which indicated moderate cognitive impairment
-She required cueing on Section C; oriented to month and day, but unable to recall the year.
-Her daily decision-making skills were moderately impaired.
-She had the following diagnoses marked under section I: Alzheimer's disease, dementia, Parkinson's disease, anxiety, and depression.

14. Review of resident 40's EMR revealed:

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F 689	Continued From page 28 *She was admitted on 2/16/19. *Her quarterly MDS assessment dated 12/10/24 included the following: -Under section C for cognitive patterns, the Staff Assessment for Cognitive Patterns was utilized rather than the BIMS assessment. -She had short-term and long-term memory issues. -She was unable to recall. -Her daily decision-making skills were moderately impaired. -She had the following diagnoses marked under section I: Dementia, and depression. 15. Review of resident 44's EMR revealed: *She was re-admitted on 6/5/21. *Her quarterly MDS assessment dated 12/31/24 included the following: -Under section C for cognitive patterns, the Staff Assessment for Cognitive Patterns was utilized rather than the BIMS assessment. -She had short-term and long-term memory issues. -She was unable to recall. -Her daily decision-making skills were severely impaired. -She had the following diagnoses marked under section I: Alzheimer's disease, dementia, anxiety, and depression. 16. Review of resident 46's EMR revealed: *She was re-admitted on 9/17/24. *Her significant change MDS assessment dated 1/17/25 included the following: -She had short-term and long-term memory issues. -She was unable to recall. -Her daily decision-making skills were severely impaired.	F 689		

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F 689	Continued From page 29 -She had the following diagnoses marked under section I: Alzheimer's disease, dementia, and anxiety. 17. Review of resident 69's EMR revealed: *She was admitted on 12/18/24. *Her admission MDS assessment dated 12/24/24 included the following: -She had a BIMS assessment score of 9, which indicated moderate cognitive impairment -She had short-term and long-term memory issues. -She had recall impairment. -Her daily decision-making skills were moderately impaired. -She had the following diagnoses marked under section I: Alzheimer's disease, dementia, anxiety, and depression. 19. Interview on 1/30/25 at 5:37 p.m. with director of nursing B revealed: *She stated, "Products labeled with "Keep Out of Reach of Children" for every resident that was cognitively impaired were to be kept up on closet shelves." "Like mouthwash, we don't want them to drink the entire bottle." *She stated, "Residents more cognitively impaired are assisted in the bathroom and supervised." *She agreed that products in resident rooms on lower shelves in bathrooms, in 3-drawer bins, on window ledges or on the dressers were accessible to residents in the memory care unit. -She confirmed there was no process or policy in place to determine and what products for which residents should have been stored to ensure the environment remained as free of accident hazards as possible.	F 689		

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F 732	Continued From page 30	F 732		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever	F 732	1. The identified staffing template has been updated to reflect the required information that must be posted in the facility and prominent areas and posted on 2/17/25. 2. The daily staffing template will include the facility name, Current date, resident census, and total number of hours worked per shift for RN, LPN, and CNA. All residents potentially were affected by the scheduled location posting. 3. On 2/18/2025, the administrator and DON educated the staffing scheduler and nursing staff through in-service education or the Paycom online portal. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal. The staffing coordinator will fill in all the identified areas on the template and post them to visible locations for staff, resident, and visitor reference. After hours and on weekends, the Rehab charge nurse will post the template in the respective areas. To ensure compliance, the DON or designee will conduct audits daily for one week, twice a week for two weeks, and then monthly for two months.	2/21/2025

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F 732	Continued From page 31 is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure the posted daily staff data: *Was displayed in a prominent area accessible to all residents and visitors. *Included the resident census. *Included the total number and the actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per shift and the resident census. Findings include: 1. Observation on 1/30/25 at 4:42 p.m. throughout the entire building revealed the nurse staffing data was located in an inconspicuous location near the visitor screening station to the right of the front desk. The staffing data was not posted anywhere else in the building, including the locked memory care units. 2. Review of the posted staffing data for 1/30/25 revealed: *The resident census was not included. *There were three sections for each shift. Each section was divided by resident unit. *Staff names were displayed for each shift they were working. *There was no distinction between registered nurses and licensed practical nurses. *The total number of nurse staffing hours was not included for each shift. 3. Interview on 1/30/25 at 5:18 p.m. with director of nursing B revealed: *The nurse staffing data was only posted at the front desk.	F 732	4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

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F 732	Continued From page 32 *She indicated that the staffing data was supposed to have been posted more prominently, such as in front of the receptionist, rather than by the visitor screening station. *She agreed that not all residents had access to the posted staffing information. *She was not aware of all the requirements for the posted nurse staffing data, such as the resident census and the total hours worked per nursing discipline. *They did not have a policy regarding the posted nurse staffing data.	F 732		
F 811 SS=E	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are	F 811	1. The identified residents in 2567 and any resident needing assistance will no longer be assisted by feeding assistants starting 2/19/2025. Due to facility discretion from speech-language pathologist recommendations for residents deemed to be able to be assisted by feeding assistants and the given education curriculum, only certified nurse aides will help with feeding residents. The feeding aide position will be dissolved effective 2/19/25. 2. On 2/18/2025, the administrator and DON educated feeding assistants and nursing staff through in-service education or the Paycom online portal. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal.	2/21/2025

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F 811	Continued From page 33 not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure five of five residents (6, 7,15, 19, and 41) who received a pureed diet and assessed to have complicated eating problems were not assisted to eat by paid feeding assistants. Findings include: 1. Observation and interview on 1/28/25 between 11:42 a.m. and 12:08 a.m. with cosmetologist AA in the Dixie dining room revealed: *Cosmetologist AA was seated next to resident 19 at the assisted dining table. *Cosmetologist AA was trained as a hair stylist, certified to assist in the kitchen, and had completed a training program for paid feeding assistants. She was not a certified nursing assistant (CNA). *Resident 19 had a recent weight loss, was on a pureed diet due to pocketing of food, and had recently began receiving hospice services. *Resident 19 was served a plate with mashed potatoes with gravy, pureed meat, and a dish that contained pureed pie. *Cosmetologist AA assisted resident 19 in eating with a spoon and drinking from a cup with two handles and a lid. *Cosmetologist AA asked another staff to reposition resident 19 in her wheelchair because she was leaning back.	F 811	Education provided for licensed and unlicensed staff about the role and responsibilities of assisting during dining service. The policy and procedure were reviewed and revised by the administrator, DON, IDT, RD, speech, and medical director. The speech therapist or designee will audit the dining room to ensure certified nurse aides are the only staff members assisting residents with meals and assisting them in a timely manner. The audit will be twice a week for three weeks, then monthly for two months. 3. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

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F 811	Continued From page 34 2. Observation on 1/29/25 at 11:32 a.m. in the dining room with licensed practical nurse (LPN) L revealed LPN L administered medication to resident 19 by spoon. 3. Interview on 1/29/25 at 11:34 a.m. with LPN L and administrator A revealed: *LPN L confirmed that resident 19 took her medications "crushed" and was on a pureed diet. -She stated resident 19 "chews and chews" her food. *Speech therapist (ST) G had recommended a "downgrade" of resident 19's food textures and the pureed diet had been ordered by hospice. *She confirmed that cosmetologist AA assisted resident 19 in eating her meals because she had a "connection" with resident 19. *Administrator A confirmed that cosmetologist AA was a paid feeding assistant and not a CNA. *Staff development coordinator (SDC) H oversaw the paid feeding assistant program and was new to that role. 4. Continued observation and interview on 1/29/25 at 11:48 a.m. in the Dixie dining room revealed: *Resident 19 was assisted in eating a pureed meal by cosmetologist AA. *Resident 41 was assisted in eating a pureed meal by activities aide (AA) Y. -AA Y confirmed she worked in the activities department, was a paid feeding assistant and not a CNA. 5. Interview on 1/29/25 at 12:04 p.m. with ST G, director of nursing (DON) B, and administrator A revealed they had approached the surveyor and confirmed that ST G had downgraded resident 19's diet to pureed.	F 811		

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F 811	Continued From page 35	F 811		

6. Interview on 1/29/25 between 12:21 p.m. and 12:35 p.m. with SDC H and ST G regarding the paid feeding assistant program revealed:
*SDC H was new in the role of staff development coordinator and oversaw the paid feeding assistant program since August 2024.
*The provider had transitioned from the textbook training format to the online format during that time.
*She confirmed that cosmetologist AA and AA Y were paid feeding assistants and not CNAs.
*She was unsure if the training covered the topic of residents with special diets, such as pureed.
*ST G stated she screened residents for swallowing difficulties at admission, quarterly, with any significant changes or when the nurse requested.
*ST G stated that she determined which residents could have been assisted by paid feeding assistants.
*Issues related to dental problems, oral issues, the need for altered food textures, and a pureed diet were not considered "complicated" feeding issues.
*Issues like a feeding tube, choking, pocketing food, requiring to be fed on one side of the mouth, aspiration, and the need for special strategies to swallow would have been considered "complicated" feeding issues.
*The decision for resident participation in the feeding assistant program was made by the interdisciplinary team based on ST G's recommendation and it was care planned.

7. Review of the provider's 1/27/25 Feeding Assistant List revealed:
*Sixteen residents were participating in the Feeding Assistant program.

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

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F 811	Continued From page 36 *There were no residents listed under the "Requiring CNA's [CNAs] to Feed." 8. Review of resident 6's electronic medical record (EMR) revealed: *She received a pureed diet. *Her care plan indicated on 5/29/24 that she, "did agree to a pureed texture for her foods. Daughter states [resident 6] can't chew the chopped-up food even now." *She "does have swallowing problems occasionally." *She was screened by speech therapy twice in April 2024 for "swallowing concerns." *There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant. 9. Review of resident 7's EMR revealed: *She received a pureed diet. *Her care plan revealed, "Nutrition risks include: cognition, dysphagia [difficulty swallowing]." *"Dependent assist of 1 [one] for eating." *There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant. 10. Review of resident 15's EMR revealed: *She received a pureed diet. *Her care plan revealed, "Nutrition Risk factors include: cerebral Infarction [a stroke], dementia, hemiplegia [paralysis of one side of the body], dyshagia [dysphagia]." *She had "some difficulties with eating when her dentures are in." *A care plan intervention included "Monitor/document ability to chew and swallow." *There was no documentation in the care plan	F 811		

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that indicated that she was assisted by a paid feeding assistant.

11. Review of resident 19's EMR revealed:
*She received a pureed diet.
*A 1/24/25 speech therapy screen indicated a referral was made due to "pocketing solids."
*A 1/28/25 progress note indicated the feeding assistant reported "patient was a little "gaggy" this morning."
*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.

12. Review of resident 41's EMR revealed:
*She received a pureed diet.
*She had a diagnosis of dysphagia.
*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.

13. Interview on 1/30/25 at 8:43 a.m. with AA EE revealed:
*She was an activities assistant and had completed the paid feeding assistant training.
*She assisted residents with eating about once a month.
*She was allowed to assist any resident who needed assistance with eating.
*No one told her which residents to assist with eating.

14. Interview on 1/30/25 at 9:41 a.m. with AA Z revealed:
*She was a paid feeding assistant.
*Resident 15 was on a pureed diet, required assistance to eat, and sometimes coughed with liquids.
*Resident 7 was on a pureed diet, required

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F 811	Continued From page 38 assistance to eat, and AA Z did not think resident 7 had any swallowing issues. 15. Interview on 1/30/25 at 3:35 p.m. with SDC H and ST G regarding the paid feeding assistant program revealed: *ST G had assessed residents 6, 7,15, 19, and 41 who had pureed diets and had deemed them safe to participate in that program because "They no longer need specific strategies." *ST G stated that a paid feeding assistant could assist a resident who had pocketed regular food but did not pocket pureed food because they no longer had a problem. *Only residents with a feeding tube or who require a very specific feeding strategy would be disqualified from the paid feeding assistant program. *Residents who placed food on one side of their mouth needed to have a CNA feed them. 16. Interview on 1/30/25 at 4:41 p.m. administrator A, DON B, and SDC H regarding the paid feeding assistant program revealed: *The "Feeding Assistant List" that was provided included all the residents within the facility who required assistance with eating. *SDC H stated that paid feeding assistants were able to assist any resident not deemed by the speech therapist, to need assistance from a CNA. *Administrator A stated that a feeding assistant could assist any resident in the facility except those who have been excluded. *At that time there were no residents that should have been excluded. *DON B stated care plans did not indicate which residents were in the paid feeding assistant program because it could change. -The care plan may include if they could not be	F 811		

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fed by a feeding assistant, but because there was not anyone excluded, no care plans contained that information.

17. Review of the provider's revised April 2020 Assisted Dining: The Role and Skills of Feeding Assistants textbook revealed:
*"Paid feeding assistants are only permitted to assist residents who have no complicated eating or drinking problems as determined by their comprehensive assessment. Examples of residents that a paid feeding assistant may assist include residents who are independent in eating and/or those who have some degree of minimal dependence, such as needing cueing or partial assistance, as long as they do not have complicated eating or drinking problems."
*"Important! Feeding assistants are not permitted to feed residents with dysphagia."
*"Residents with dysphagia have difficulty or discomfort when swallowing."
*"Symptoms of dysphagia include: Coughing before, during or after swallowing food, liquid or medication... Pocketing food in the side of the mouth ..."

18. Review of the provider's February 2010 Dining Assistants policy revealed:
*"Assisted dining will be provided to appropriate residents when necessary in accordance with applicable federal and state requirements regarding Feeding Assistants."
*"An [A] FA [feeding assistant] is to feed only those residents who have no complicated eating problems. Complicated eating problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, tube or parenteral/IV [intravenous] feedings, paralysis, trauma or facial, oral or neck surgery or any other complicating

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F 811	Continued From page 40 condition as, high risk for choking, depressed cough or gag reflex, needing positioning during feeding or decreased gastric motility."	F 811		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 849	1. Identified resident 19 had a hospice care plan created and developed on 1/30/25. Physician order verified on 1/29/25. 2. On 2/20/2025, an initial audit was completed of residents currently on hospice services within the facility to ensure a physician's order and hospice care plan were current. No other residents were identified as having a missing care plan or order. 3. On 2/18/2025, the DON educated the IDT team through in-service education or the Paycom online portal regarding the timeline for the hospice care plan and ensuring there is a physician order in the EMR. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal. The IDT team will ensure that residents who transfer to hospice services have a joint plan of care in place and is accessible to nursing staff. The DON or designee will conduct weekly audits for admitted hospice residents and ensure a physician order was received for two weeks for any residents transitioning to hospice services and monthly for three months.	2/21/2025

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F 849	Continued From page 41 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal	F 849	4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

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F 849	Continued From page 42 illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in	F 849		

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F 849	Continued From page 43 the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both	F 849		

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the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the Hospice and Nursing Facility Services Agreement, the provider failed to ensure an integrated plan of care had been developed and made accessible between the provider's nursing staff and hospice agency for one of one sampled resident (19) who received hospice services. Findings include:

1. Observation and interview on 1/28/25 between 11:42 a.m. and 12:08 a.m. with cosmetologist AA in the Dixie dining room revealed:
*Cosmetologist AA was seated next to resident 19 at the assisted dining table.
*Resident 19 had a recent weight loss, was on a pureed diet due to pocketing of food, and had recently began receiving hospice services.

2. Interview on 1/29/25 at 11:34 a.m. with licensed practical nurse (LPN) L revealed resident 19 had gallstones, no surgery was recommended, and she began receiving hospice services about two weeks ago.

3. Interview on 1/29/25 at 3:07 p.m. with registered nurse (RN) K and staff development coordinator (SDC) H at the North Oak nurses' station regarding hospice revealed:
*There was only one hospice provider the facility used, and they were available by phone 24 hours a day seven days a week.
*Communication of when the hospice nurse

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would return to complete wound care or baths was provided verbally and in the electronic medical record (EMR) system.
*There was no specific binder or paper records available at that nurse's station regarding resident 19's hospice plan.

4. Review of resident 19's EMR revealed there was no documentation that a physician's order for hospice had been received.

5. Interview on 1/29/25 at 3:38 p.m. with hospice RN GG revealed:
*Consent forms were kept in the resident's paper medical record.
*She documented her assessments, phone number, and the date of the next visit directly in the resident's EMR.

6. Review of resident 19's current facility care plan revealed:
*She had been admitted to the facility on 4/26/18.
*Her diagnoses included mild intellectual disabilities, osteoarthritis, anemia, heart failure, fracture of left patella, acute kidney failure, anorexia, and anxiety disorder.
*A nutrition focus area indicated, "Currently on hospice" was revised on 1/28/25.
*The nutrition goal indicated, "Comfort Care Nutrition provided due to hospice."
*The nutrition interventions included, "1/28/24: Admitted to hospice on 1/17 [2025] due to recent diagnosis of Calculus of Gallbladder with Acute Cholylith [Cholelith (gallstones)] with back pain. General surgeon recommends comfort cares over surgical intervention."

On 1/29/25 a request was made to director of nursing (DON) B for resident 19's hospice care

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plan and physician order.

7. Interview on 1/30/25 at 8:19 a.m. DON B regarding hospice services revealed:
*On 1/29/25 she had contacted hospice for a copy of resident 19's care plan.
-Hospice was to put together a care plan and review it weekly with the medical doctor.
*A hospice care plan was to be kept in the front of resident 19's paper medical chart and contained the contact number and the services that hospice staff provided.
*She obtained a copy of resident 19's hospice physician's order on 1/29/25.
*The joint care plan had not been completed.
*She expected the facility care plan to be updated with the specific hospice plan by each department when resident 19 started receiving those services.
*Hospice documented their notes directly in the EMR if there were any concerns.

8. Interview on 1/30/25 at 8:52 a.m. CNA FF regarding identifying residents receiving hospice revealed:
*She identified resident 19 received hospice services.
*That information was provided to her by the nurse, and it was to be on the pocket care plan.
*Hospice visited resident 19 one to two times a week to take her vitals and complete a bed bath.

9. The provided pocket care plan did not indicate that the resident received hospice services.

10. Interview on 1/30/25 at 4:19 p.m. with administrator A and DON B regarding resident 19's hospice care revealed:
*There had been a delay in getting the hospice

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admitting diagnosis for resident 19.
*She was admitted to hospice on 1/17/25.
*During the interview DON B called the hospice provider to request a copy of the physician's order and the hospice care plan.
*DON B stated she updated the facility care plan to reflect that resident 19 had been admitted to hospice and the services she received.
*She expected the care plan to reflect the specific care resident 19 received.

11. Review of resident 19's 1/30/25 updated care plan revealed:
*Her care plan included a focus area that was revised on 1/30/25, "See the MAR/TAR, Physician orders/protocol, CNA [certified nursing assistant] flow sheets and the Short Term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment in integrated therapy reports if applicable. Care plans are written by the exception reflecting facility standards. Administer medications as ordered. [Resident 19] was admitted to Hospice on 1/17/25."
*There was no resident-centered goal, it directed to "See Focus" revised on 4/16/24.
*There were no specific interventions, it directed to "See Focus" initiated on 5/9/18.

12. Review of resident 19's hospice care plan revealed:
*It was dated 1/17/25.
*The progressive disease process was gallbladder with acute cholylith (cholelith).
*"Ongoing updates will be communicated by Hospice to LTC [long-term care] and LTC will integrate changes into their care planning system. The Hospice care plan is the Plan of Treatment/485 with ongoing MD [medical doctor] orders being part of that plan. Hospice does not

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F 849	Continued From page 48 utilize a separate nursing plan of care [POC]. The LTC plan of care will reflect the most current POC at the LTC facility." That was marked with the responsibility code for hospice and long-term care. 14. A review of the provider's 1/8/13 Hospice and Nursing Facility Services Agreement revealed: *"Joint Plan of Care ... means a coordinated joint plan of care for an individual Patient for the palliation or management of the Patient's terminal illness and related conditions that (a) clearly delineates the services to be provided by Hospice and Facility; (b) is consistent with Hospice's philosophy; (c) is based on the assessment of the Patient's current medical, physical, psychological and social needs, and unique living situation; (d) reflects the participation of Hospice, Facility, the Patient and the Patient's family, as appropriate; and Euro complies with applicable federal and state laws and regulations." *Facility responsibilities included: -"Participate in Development of JPOC" -"Coordination with Hospice Staff in implementation and update of Joint Plan of Care." *"Joint Responsibilities/Mutual Promises. Development and Implementation of Plan of Care ....Hospice and Facility shall jointly develop and agree upon the Patient's Joint Plan of Care ....Hospice and Facility each shall maintain a copy of each Patient's JPOC in the respective clinical records maintained by each Party."	F 849		
F 880 SS=F	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. The identified used personal hygiene items in Pine Village shower room removed and disposed of properly. Residents 62, 68, 25, 6, and 66 were reassessed for appropriate EBP and TBP with signs placed in resident rooms on 2/17/25.	2/22/2025

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F 880	Continued From page 49 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	All residents were reviewed for appropriate EBP, and TBP was conducted. PPE carts outside the residents' rooms were restocked and reorganized to supply proper gown and glove use on 2/17/25. Pocket care plans were updated to reflect the precautionary needs of identified residents 2/19/25. Staff members CNA W, LPN P, LPN DD, LPN N, and SDC H were given education on appropriate hand hygiene practices on 2/19/25. Resident 68, with her consent, was transitioned to a private room. 2. IPC completed an initial audit to ensure correct signage, PPE availability, pocket care plan for EBP and TBP updated, proper PPE used, proper hand hygiene, and used resident products disposed of. 3. IPC, DON, and designee provided all staff education through directed in-service on 2/18/2025 and Paycom Portal. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal. Topics include appropriate maintenance and disposal of identified resident care items, appropriate transmission-based precautions for identified tasks, and appropriate hand hygiene and glove use for assigned tasks. IPC, DON, or designee will conduct an audit to review whether the proper signage on the door is present and if the PPE cart is stocked.	

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F 880	Continued From page 50 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, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for: *The maintenance and disposal of resident care items in one of one shower room. *Transmission based precautions by four of four staff (certified nursing assistant (CNA) T, CNA X, licensed practical nurse (LPN) P, and wound care nurse (WCN) I) for five of five sampled residents (62, 68, 25, 6, and 66) who had care concerns requiring personal protective equipment (PPE). *Hand hygiene and glove use by five of five staff (CNA W, LPN P, LPN DD, LPN N, and staff development coordinator (SDC) H) for four of four	F 880	. IPC, DON, or designee will conduct an audit to review proper PPE used by staff in TBP situations and proper disposal of used resident items; DON or designee will conduct an audit to review hand hygiene performed in the facility by staff. IPC, DON, or designee will audit the pocket care plans that reflect the appropriate EBP and TBP. The audit duration will be twice a week for three weeks and then monthly for two months for all the audits in F880. 4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

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observed sampled residents (6, 66, 59, and 328).
Findings include:

1. Observation on 1/28/25 from 9:53 a.m. to 10:36 a.m. in the shower room 282 on the Pine Village memory care unit on the second floor revealed there was:
*A used nail file and a dirty hair pick with visible hair and lint sitting on top of the wall-mounted glove box to the left of the entrance.
*A soiled plastic cup with a small amount of an unidentifiable dried green paste on top of the soap dispenser in the shower.

2. Observation and interview on 1/28/25 at 2:47 p.m. with resident 25 revealed:
*There was a stop sign on her door and a cart outside that room that contained gowns and gloves.
*She wore a boot on her left foot from a recent surgery on her toe.
*She was frustrated that she shared a bathroom with the female resident next door.

Observation and interview on 1/30/25 at 8:03 a.m. with resident 25 revealed:
*There had not been any signage on her door that indicated she was on enhanced barrier precautions (EBP).
*She stated she had one toe with a wound and a dressing on it, but the nurse had not looked at it today (1/30/25).
*She stated that staff had worn gloves but not gowns when they assisted her.

Review of her 1/24/25 weekly wound observation tool revealed resident 25 had a four millimeter (mm) by four-mm unstageable wound to her left second toe with an undeterminable depth.

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Review of resident 25's care plan revealed no indication that resident 25 required EBP.

Interview on 1/30/25 at 2:21 p.m. with wound care nurse (WCN) I and infection preventionist (IP) C who participated by phone revealed:
*Resident 25 had an open wound to her left toe.
*WCN I was unsure if resident 25 was on EBP for wound care and stated she would need to consult with the infection preventionist.
*WCN I called IP C at home to join the interview.
*IP C stated she had removed resident 25 from EBP because she did not think a Band-Aid was a dressing that required EBP.
*WCN I confirmed that resident 25 had an open wound on her left toe with a Medihoney (wound healing) dressing.
*IPC stated, "I would put her back on EBP with that information."

3. Observation on 1/28/25 at 11:12 a.m. with resident 62 and certified nursing assistant (CNA) X revealed:
*There were two signs on resident 62's door and a cart outside that room contained gowns and gloves.
-One sign indicated, "STOP please see nurse," and the other indicated, "Steps to put on PPE 1. Put on Gown and tie 2. Put on gloves."
*Resident 62 was in her room calling out, "Please come."
*CNA X entered resident 62 room and closed the door.
*The surveyor then entered the room. Resident 62 was seated on the toilet and CNA X was not wearing a gown or gloves.
*CNA X exited the bathroom and without completing hand hygiene, put on a pair of gloves

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and finished assisting resident 62.

Interview on 1/30/25 at 7:49 a.m. with WCN I revealed resident 62 was on enhanced barrier precautions (EBP) for a foot wound.

Interview on 1/30/25 at 8:07 a.m. with resident 62 who used a whiteboard for communication revealed:
*Staff sometimes wore a gown and gloves when they assisted her, but some times she had to get to the toilet "so fast" that they did not.
*She indicated she had to use the shared bathroom frequently, had difficulty waiting, and sometimes had to wait for the other resident to be done in the bathroom.

Interview on 1/30/25 at 8:10 a.m. with CNA U regarding precautions revealed:
*The sign on resident 62's door indicated that staff needed to wear a gown and gloves while providing her direct care, but it was okay to go in to talk to her or deliver items to her room.
*Resident 62 had an infection in her leg.
*A sign was to be on a resident's door, and she used a pocket care plan to know which residents required staff to wear gowns and gloves while providing their direct care.
*She stated that information was also in the residents' care plans in the EMR.

The provided pocket care plan did not indicate that resident 62 required EBP.

Observation on 1/30/25 at 8:15 a.m. at the North Oak nurses' station revealed:
*A sign with a list indicated what residents in that area were on EBP.
-There were two residents on that list however

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F 880	Continued From page 54 resident 25 and resident 62 were not listed. Interview on 1/30/25 between 8:31 a.m. and 8:40 a.m. with licensed practical nurse (LPN) M and WCN I revealed: *LPN M stated resident 62 was on EBP for a heel wound and staff were to wear a gown and gloves when providing direct care. *LPN M expected to see resident 62's name on the list of residents that required EBP. *LPN M expected the CNAs to find information on which residents required EBP on the pocket care plan. *WCN I stated that the EBP list had been updated yesterday (1/29/25) and that residents with wounds and catheters that required the use of EBP were on that list. *Signs were to be on those resident room doors. *Residents who required precautions for COVID-19 or contact precautions would be listed on a separate sign. *There were no other lists or signs at that nurse's station. *There were no residents in the North Oak area on COVID-19 or contact precautions. Review of resident 62's EMR revealed: *She was admitted on 10/1/24 with a diabetic ulcer (wound) on her right foot. *Her care plan indicated "hx [history] of MRSA [methicillin-resistant Staphylococcus aureus]" from the wound on her right foot. *The care plan indicated, "CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry." *There was no documentation in the care plan	F 880		

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that indicated the staff were to use a gown or gloves with resident contact.

Interview on 1/30/25 at 12:57 p.m. with LPN M regarding resident 62's MRSA culture revealed:
*Resident 62's daughter stated that the last culture of that wound had been done at the hospital prior to her admission to the facility.
*She would request those culture results from IP C.
*She was unaware if the MRSA was and active infection.

Review of resident 62's printed medical record documents requested revealed:
*A 10/2/24 physician's order for "Contact precautions: May leave room for meals and therapy as long as wound is covered and not draining. Resident must wash hands with soap and water prior to leaving."
*A 9/25/24 wound culture of the right foot revealed "Positive for MRSA."

4. Observation on 1/28/25 at 2:29 p.m. of CNA T and resident 68 revealed:
*Resident 68 had a sign posted outside of her door that stated, "STOP, check with nurse before entering" and signs that indicated the correct way to put on PPE.
*There was an empty three-drawer bin in the hallway outside the resident's room, and a tub containing a clear trash bag of yellow gowns beside it.
*Resident 68 was sitting in her recliner in her room when CNA T came in without wearing a gown or gloves and told her she would be going to a doctor's appointment.
*CNA T positioned resident 68's wheelchair next to the recliner and assisted her in standing and

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transferring to her wheelchair.
*CNA T got the residents' jacket and asked if she wanted her shoes on as well, which she declined.
*CNA T pushed resident out of her room in her wheelchair and down the hallway.

Interview on 1/30/25 at 8:01 a.m. with LPN Q revealed:
*She was unsure what type of transmission-based precautions resident 68 was on.
*She thought she was on contact precautions for extended-spectrum beta-lactamase (ESBL) (bacteria that is resistant to some antibiotics) for the ulcers on her legs.

Observation and Interview on 1/30/25 at 9:56 a.m. with LPN N and M regarding resident 68 revealed:
*LPN N thought she was on enhanced barrier precautions (EBP) for the ulcers on her legs.
*LPN M thought she was on contact precautions.
*Both LPN M and N searched the resident's electronic medical record and paper chart for the resident's current transmission-based precautions type.
*They concluded that resident 68 was on contact precautions due to ESBL in her urine based on a positive culture they found on 1/16/25.
*LPN M stated that residents who have a wound or a catheter will have a stop sign by their name tag on their door that indicated to staff to see the nurse for their transmission-based precautions type.
*LPN M stated EBP is for direct patient care, contact precautions are for all cares provided to a resident.

Observation on 1/30/25 at 11:02 a.m. at resident

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F 880	Continued From page 57 68's room revealed: *Resident 68 shared a room with resident 11. *Wound care nurse I entered the resident's room without putting on any PPE. *She wheeled resident 11 out of the bathroom, installed the foot pedals on her wheelchair, and wheeled her out of the room. *When asked what type of precautions was required for the residents in that room, she indicated that resident 68 was on enhanced barrier precautions (EBP). Interview on 1/30/25 at 11:04 a.m. with housekeeper HH revealed: *The color of the stop sign coincided with the level of transmission-based precautions (TBP). *The yellow stop sign coincided with contact precautions. *There was a cheat sheet on each housekeeping cart that listed the type of TBP associated with each colored stop sign, as well as a list of diseases that the residents may have, and the level of cleaning required for each disease. *At the nurse's station, there was a list of residents, the type of TBP the residents were on, and the reason for the TBP. *She confirmed that resident 68 was on contact precautions related to ESBL in her urine. *She explained that when cleaning the room shared by resident 11 and 68, she would put on a gown, gloves, and an eye protector. *The chemical she would use to clean that room was Betco brand pH7Q Dual concentrated cleaner, which killed viruses and organisms like COVID-19, Staphylococcus aureus, pseudomona, salmonella, VRE (vancomycin-resistant enterococcus) and MRSA (methicillin-resistant Staphylococcus aureus).	F 880		

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Interview on 1/30/25 at 11:11 a.m. with LPN N revealed:
*She confirmed resident 68 was on contact precautions "because of what's in her urine."
*If staff were entering the resident's room to help resident 11 instead of resident 68, they did not need to put on PPE.
*She confirmed that both resident 11 and 68 used the same bathroom.

Interview on 1/30/25 at 12:09 p.m. with infection preventionist (IP) C revealed:
*Staff were to perform hand hygiene every time they removed gloves and before they put new gloves on.
*She expected staff to know what precautions a resident was on based on a sheet of paper posted at the nurse's desk.
*If a resident was on contact precautions, she expected staff to put on PPE (gown, gloves, goggles or face shields if there was a chance of spray back) with each entry into the resident's room.
*If a resident had ESBL in their urine and was continent, then they would downgrade the precautions from contact precautions to EBP and the resident would be able to exit their room.
*They would try not to room residents together when one of them was on a type of TBP and the other was not, such as the case with residents 11 and 68.
*She expected staff to clean the residents' shared bathroom with the purple-top sanitizing wipes (Super Sani-Cloth brand) after each time resident 68 used the bathroom.
-"Usually we do not have them share a bathroom but at times it does happen."
*She was aware that resident 68 currently had ESBL in her urine.

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F 880	Continued From page 59 -Resident 68 was continent, so they were in the process of changing her to EBP because resident 68 wished to go out of her room for meals and activities. *She confirmed that resident 11 was not on TBPs. -She indicated that staff did not need to wear a gown or gloves when assisting resident 11. Observation and interview on 1/30/25 at 12:58 p.m. with resident 68 revealed: *Staff wore yellow gowns while taking her to the bathroom. *Staff did not clean her bathroom after she used it. *No purple disinfectant wipes were found in her bathroom or within proximity of her room. Interview on 1/30/25 at 1:00 p.m. with CNA W revealed: *Housekeeping cleaned the residents' bathrooms once a day. *Staff would clean resident 68's bathroom if it was "obviously soiled." Interview on 1/30/25 at 3:05 p.m. with director of nursing (DON) B revealed: *She confirmed she was aware that resident 68 had ESBL in her urine. *She confirmed that residents 11 and 68 shared a bathroom. -When asked about cleaning the residents' shared bathroom after resident 68 used it, she said, "I would hope that it would be happening." *Staff were to clean their bathroom with the purple-top wipes after each time resident 68 used the bathroom. *If the purple-top wipes were not available, staff had the option to carry around a small package of sanitizing wipes.	F 880		

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F 880	Continued From page 60 *She stated not cleaning the residents' shared bathroom put resident 11 at risk for contracting ESBL. *She expected staff to wear PPE when providing care for residents on EBP and contact precautions. Review of resident 68's electronic medical record revealed: *She was admitted on 12/20/24. *She had a Brief Interview for Mental Status (BIMS) assessment score of 12 indicating she had moderate cognitive impairment. *Her diagnoses included weakness, acute kidney injury, and ESBL resistance. *Her active contact precaution order started on 12/20/24. *There was an order for staff to clean her arterial ulcers on her right lower extremity (RLE) daily with soap and water and to cover them with an appropriate dressing. *There was no documentation in her care plan that indicated she was on contact precautions or EBP. 5. Observation and Interview on 1/28/25 at 3:02 p.m. of resident 6 in her room revealed: *There was a sign with a stop sign on it next to her name badge outside of her room. *There was a three-drawer organizer with PPE supplies in it outside of her room. *She was lying in bed, with a pillow propped under her left side, and a call light button on the moveable tray table in front of her. *She stated she had a sore on her coccyx, but they had told her it was healing. *Staff were to change the pressure ulcer (PU) dressing every day.	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 01/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61	F 880		

Interview on 1/29/25 at 8:35 a.m. with LPN O regarding resident 6's PU revealed:
*She stated the PU has shown a lot of improvement.
*It was considered a facility acquired stage 4 PU.

Observation and interview on 1/30/25 at 10:44 a.m. of resident 6 while receiving a shower (after obtaining permission by the resident) in the bathroom with CNA W and staff development coordinator (SDC) H revealed:
*Resident 6 was in a shower chair, CNA W and SDC H were both wearing a gown and gloves.
*Once the shower was completed, both the staff members dried resident 6 with towels and covered her with blankets.
*Both staff members removed their PPE (gown and gloves), but did not perform hand hygiene.
*CNA W did not put on clean gloves before transporting resident 6 to her room.
*SDC H and CNA W applied new gowns once inside her room.
*SDC H performed hand hygiene and put on new gloves.
*CNA touched the bed comforter on the residents' bed before putting on clean gloves.
*Both staff members assisted resident 6 from the shower chair to her bed using a full body mechanical lift (lift and sling used to lift a person's full body).
*There was a moveable tray table that had a black plastic bag that was used as a barrier for the clean wound dressing supplies.
*LPN N entered the room wearing a gown, performed hand hygiene, and put on clean gloves.
*LPN N then:
-Removed the dirty wound dressing and discarded it.

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	435036	A. BUILDING ____ B. WING ____	C 01/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 62	F 880		

-Removed her gloves and discarded them.
-Retrieved a clean package of gauze from the bedside table, opened it, and set it on the bed comforter without a barrier under it.
-Performed hand hygiene and then put on clean gloves.
-Retrieved the wound cleanser from the bedside table and gauze from the package on the bed comforter.
-Sprayed the wound cleanser directly onto the wound and dried the wound with the gauze.
-Removed her gloves, performed hand hygiene, and put on new gloves.
-Applied collagen with silver to the wound bed, packed the wound with calcium alginate, and covered the wound with an adhesive dressing.
-Removed her gloves and discarded them.
-LPN N did not perform hand hygiene then picked up the leftover unused supplies from the resident's bedside table.

Review of resident 6's EMR revealed:
*She was admitted on 1/3/2018.
*She had a BIMS assessment score of 14 which indicated she was cognitively intact.
*She had an order for a wound dressing change daily and as needed started on 12/6/24 for her PU.
*There was no documentation that indicated the resident was on EBP in her care plan.

6. Observation on 1/29/25 at 3:18 p.m. with LPN P during administration of resident 59's eye ointment revealed she did not perform hand hygiene before she put on her gloves before she administered that ointment or after she removed those gloves after she completed the administration of that eye ointment.

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	435036	A. BUILDING ______ B. WING ______	C 01/30/2025

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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 63 7. Observation and interview on 1/29/25 at 3:50 p.m. with CNA X, LPN P, and WCN I during resident 66's wound dressing change in her bathroom revealed: *There was a sign by the resident's name badge on her door with a stop sign on it. *There was no PPE inside or outside of resident 66's room. *CNA X was wearing gloves but no gown while assisting resident 66 in the bathroom with her toileting cares. *LPN P and WCN I both performed hand hygiene and put on gloves but no gowns. *After CNA X was finished helping resident 66, she removed and discarded her gloves, performed hand hygiene, and left the room. *While resident 66 was still in the bathroom, LPN P removed the adhesive wound covering and sprayed a disinfectant spray on the wound located on resident 66's coccyx (tailbone area). *LPN P blotted the area with a clean towel. *WCN I handed LPN P the opened wound care products that included a honey fiber pad for packing the wound and an adhesive covering. *LPN P applied the wound care products and then assisted resident 66 in pulling up her incontinence brief and pants and then transferred her to her wheelchair. *LPN P and wound care nurse I both then removed their gloves, discarded them, and performed hand hygiene. *They stated they should have worn a gown and gloves because the resident was on EBP due to her wound. *LPN P stated, "I'm the one at risk" so if the resident had some sort of infection, she would have put on a gown to protect herself. Review of resident 66's EMR revealed:	F 880		

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	435036	A. BUILDING ______ B. WING ______	C 01/30/2025

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F 880	Continued From page 64 *A 1/13/25 active order for wound care related to her PU. *There was no documentation that indicated she was on EBP in her care plan. 8. Observation on 1/30/25 at 8:04 a.m. with LPN DD revealed: *She did not perform hand hygiene before she applied gloves prior to administering a medication to be taken by mouth to resident 328. 9. Review of the provider's undated Enhanced Barrier Precautions Policy and Procedure revealed: *"It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs)." *"Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." *"High-contact resident activities may include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any opening requiring a dressing ..." *"Examples of MDROs Targeted by CDC include: Methicillin-resistant Staphylococcus aureus (MRSA), ESBL-producing Enterobacterales, Vancomycin-resistant Enterococci (VRE) ..." *"Contact precautions are recommended if the resident has acute diarrhea, draining wounds, or other sites of secretions that are unable to be covered or contained for a limited period of time	F 880		

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	435036	A. BUILDING ______ B. WING ______	C 01/30/2025

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F 880	Continued From page 65 during a suspected or confirmed MDRO outbreak investigation." *"2. Gowns and gloves will be available immediately near or outside of the resident's room. Face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care)." *"8. Enhanced barrier precautions should be used for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling device that placed them at a higher risk." 10. Review of the provider's revised 9/2021 Infection Prevention and Control Manual regarding Hand Hygiene policy revealed: *"Hand Hygiene includes hand washing with soap and water and hand hygiene with alcohol-based hand rub (ABHR.)" *"Hand hygiene continues to be the primary means of preventing the transmission of infection." 11. Review of the provider's reviewed 9/2022 Contact Precautions policy revealed: *"Contact Precautions will be used to prevent the healthcare acquired spread of organisms that can be transmitted by direct resident contact (hand or skin-to-skin contact that occurs when performing resident-care) or by indirect contact (touching) with environmental surfaces or contaminated resident care equipment." *"Healthcare personnel caring for residents on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment." 12. Review of the provider's reviewed 6/2023	F 880		

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F 880	Continued From page 66 Guidance for Control of Extended-Spectrum Beta-Lactamase (ESBL) policy revealed: *"The purpose of this policy is to provide guidelines for prevention and control of ESBL." *"Prevention -A. Appropriate resident placement -B. Gloves for all activities in resident's room -C. Gowns indicated for activities where skin or clothing will come in contact with the resident or their environment or when performing direct care -D. Dedicated equipment or adequate cleaning and disinfection of shared equipment, with particular attention to management of urinary catheters and associated equipment" *"Cohort symptomatic residents with ESBL in specific areas if possible." *"The environment of a resident with ESBL should be cleaned thoroughly at least daily, with special attention to those items likely to be contaminated."	F 880		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure call light systems were accessible to residents in two of two observed resident shower/tub rooms, and five of eleven observed	F 919	1. Identified resident call lights in 273, 278, 280, 286, and 288 were replaced or ensured the call light cord was the appropriate length to the floor. Shower room 282 had a call light system in place, but an additional call light button was provided that would be accessible within the tub room. Maintenance tested and verified all installed call lights as functional. 2. The maintenance director's initial audit on 2/19/2025 ensured that all call lights in resident care areas were present and functioning correctly.	2/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 919	Continued From page 67 resident bathrooms (rooms 273, 278, 280, 286, and 288). Findings include: 1. Observation on 1/29/25 from 9:33 a.m. to 10:05 a.m. in the 2nd floor memory care unit revealed: *The wall-mounted call light in the bathroom of resident room 273 did not have a pull cord and was not accessible if a resident was on the floor. *The cord for the wall-mounted call light in the bathrooms of resident rooms 278, 280, 286, and 288 was wrapped around the call light box and was not accessible if a resident was on the floor. *There was no call light available in the shower room 282. *The wall-mounted call light in the tub room did not have a pull cord and was not accessible if a resident was on the floor. 2. Interview on 1/30/25 at 3:12 p.m. with activity aide Z revealed: *The shower room was "rarely" used, but the toilet in that room was used for residents. *She was not aware that there was no call light available in that room. 3. Interview on 1/30/25 at 3:27 p.m. with licensed practical nurse (LPN) R revealed: *He was not aware that the shower room did not have a call light available. *The shower in the shower room was never used, but the toilet was used by residents "frequently." *He said, "I don't leave them alone, but I do stand outside on the other side of the door until the resident is done." *He agreed there should be functioning call lights in resident areas. *If a call light was not functioning, he would "call	F 919	3. The administrator and DON provided education through staff in-service on 2/18/2025 and the Paycom Portal. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal. Nursing staff education covers proper placement and accessibility of call lights, how to report and document a call light malfunction, and where the call light should be located. Maintenance staff will complete monthly call light checks to ensure the functionality and placement of call lights. Front-line staff will continue to notify maintenance when there is a call light malfunction. The administrator or designee will conduct audits weekly for 3 weeks and then monthly for 2 months to ensure call light functionality and appropriate response to call light malfunctions. Policy reviewed and revised. 4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

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	435036	A. BUILDING ______ B. WING ______	C 01/30/2025

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F 919	Continued From page 68 maintenance." 4. Interview on 1/30/25 at 5:19 p.m. with administrator A revealed: *They did not have a policy regarding the minimum requirements for call lights. *He indicated he thought a call light was not necessarily needed in the shower room "because a staff member would be in the room with the resident at all times." -He felt that staff would have used their radios if they needed help. *The maintenance department completed call light audits for functionality. This surveyor requested to review that documentation. That documentation was not provided by the end of the survey.	F 919		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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	01/28/2025

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

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K 000	INITIAL COMMENTS A recertification survey was conducted on 1/28/25 for compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. Jenkin's Living Center (building 01) was found not in compliance. The building (building 01) will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/28/25. Please mark an F in the completion date column for K225 deficiencies identified as meeting the FSES, 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 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 1/28/25 at 11:39 a.m. revealed the west stair connecting the first and second level was not provided with a landing at the	K 225		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kasey Klapprodt	President / CEO	2/24/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	**01/28/2025**

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

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K 225	Continued From page 1 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		

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	**01/28/2025**

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

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K 000	INITIAL COMMENTS A recertification survey was conducted on 1/28/25 for compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. Jenkin's Living Center (building 02) was found not in compliance. The building (building 02) will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/28/25. Please mark an F in the completion date column for K225 deficiencies identified as meeting the FSES, 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 provider failed to ensure conforming exit stairs for two of two stairs (east and west stairs) were not conforming. Findings include: 1. Observation on 1/28/25 at 1:10 p.m. revealed the door swinging into the second-floor west stair enclosure reduced the landing to 21 inches.	K 225		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kasey Klapprodt
TITLE: President / CEO
(X6) DATE: 2/24/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 ______	**01/28/2025**

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

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K 225	Continued From page 1 Observation at 3:24 p.m. on 1/28/25 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		

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

PRINTED: 02/13/2025
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 **03 - BUILDING 03** B. WING ______	**01/28/2025**

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

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K 000	INITIAL COMMENTS A recertification survey was conducted on 1/28/25 for compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. Jenkin's Living Center (building 03) was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kasey Klapprodt	President / CEO	2/24/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 ______	**01/28/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 1/28/25 for compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. Jenkin's Living Center (building 04) was found not in compliance. The building (building 04) will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/28/25. Please mark an F in the completion date column for K225 deficiencies identified as meeting the FSES, in conjunction with the provider's commitment to continued compliance with the fire safety standards. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K342 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: 2/24/2025

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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 ______	**01/28/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 1/28/25 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 342 SS=D	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and testing, the provider failed to ensure manual initiation means of the fire alarm system for one randomly	K 342	1.During the on-site survey, the protective cover trim ring that was interfering with the activation of the manual pull station was removed. 2.All pull stations were inspected, and any having the protective cover were removed on 2/17/2025.	2/17/2025

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	435036	A. BUILDING **04 - BUILDING 04** B. WING ______	**01/28/2025**

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

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K 342	Continued From page 2 observed location (3rd floor manual alarm box near the west stair enclosure). Findings include: Observation on 1/28/25 at 3:53 p.m. during the fire drill on the 3rd floor revealed the manual alarm box (pull-station) near the west stair enclosure had a protective cover over it to deter residents from pulling it. Further observation at that same time revealed a staff person responding to the simulated fire of the fire drill. That staff person removed the protective cover from the pull-station and then pulled down on it, to manually initiate the building's fire alarm system. After waiting a few seconds for the alarm to sound the responding staff person appeared confused as to why the alarm had not sounded. That staff person then tried again to activate the alarm by pulling the pull-station a second and third time. At this point the maintenance technician intervened, and proceeded to unlock the pull-station's halves to investigate why it was not initializing the alarm. When he unlocked the pull-station and swung the front half down away from the wall, the switch inside activated the buildings alarm. Interview with the maintenance technician at that same time revealed he believed the pull-station was not traveling far enough downward for activation because the protective covers trim ring was limiting travel. Testing at the same time as the interview confirmed that finding. The deficiency had the potential to affect 100% of the building occupants.	K 342	3.The maintenance director was educated that fire alarm systems need to be functional so that staff can activate them in an emergency. During the monthly fire drill for the next three months, the maintenance director will verify that all fire pull stations are working and functional. After three months, a quarterly inspection of the fire pull stations and an annual inspection will ensure that the pull stations are working appropriately. 4.The IDT team will review initial and ongoing adults weekly and then monthly through the QAPI process.	

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

PRINTED: 02/13/2025
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 **05 - BUILDING 05** B. WING ______	**01/28/2025**

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

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K 000	INITIAL COMMENTS A recertification survey was conducted on 1/28/25 for compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. Jenkin;s Living Center (building 05) was found in compliance.	K 000		

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

TITLE: President / CEO

(X6) DATE: 2/24/2025

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South Dakota Department of Health

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	10703	A. BUILDING: ______ B. WING ______	01/30/2025

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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/28/25 through 1/30/25. Jenkin's Living Center was found in compliance.	S 000		
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 1/28/25 through 1/30/25. Jenkin's Living Center was found not in compliance with the following requirements: S169, S206, S210, and S301.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically-activated audible alarm on all unattended exit doors. Any other exterior doors must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence when the door is closed; (7) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in the facility; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the	S 169	1. The door alarm system requires a panel, which is a key part of the system, for continued notification to meet compliance. This part was ordered through the vendor on 2/17/25. The vendor will install the part on 3/3/25. 2. Education was provided to staff through service on 2/18/2025 and the Paycom online portal. Confirmation of completion will be identified through a sign-off sheet for the service or the attestation staff sign in Paycom Portal. The door alarms must stay on until a staff member physically turns them off.	3/3/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kasey Klapprodt
TITLE: President / CEO
(X6) DATE: 2/27/2025

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
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S 169	Continued From page 1 provider failed to ensure all unattended exit doors were equipped with a non-automatically silencing, electrically-activated audible door alarm, for three randomly observed exit doors (ambulance garage entrance, building 02 west stair tower exit, and the building 03 west stair tower exit). Findings include: 1. Observation on 1/28/25 at 12:03 p.m. revealed the exit door for the ambulance garage was provided with an electrically-activated audible door alarm. Testing of that door alarm revealed the door alarm would automatically reset when the door closed. Further testing of that door alarm revealed staff members did not respond to that door alarm over a period of more than ten minutes and multiple soundings of the alarm. Interview with the maintenance technician at that same time confirmed that finding. 2. Observation on 1/28/25 at 1:30 p.m. revealed the exit door for the building 02 west stair tower exit was provided with an electrically-activated audible door alarm. Testing of that door alarm revealed the door alarm would automatically reset when the door closed. Further testing of that door alarm revealed staff members did not respond to that door alarm over a period of more than five minutes and multiple soundings of the alarm. Interview with the maintenance technician at that same time confirmed that finding. 3. Observation on 1/28/25 at 1:58 p.m. revealed the exit door for the building 03 west stair tower exit was provided with an electrically-activated audible door alarm. Testing of that door alarm revealed the door alarm would automatically reset when the door closed. Further testing of that door alarm revealed staff members did not respond to that door alarm over a period of more than five	S 169	The education covers how to respond promptly to an Alarm activation, how to reset the alarms, and who to report the alarm to if it does not function appropriately. The administrator or designee will conduct audits weekly for 3 weeks and then monthly for 2 months to ensure call light functionality and appropriate response to call light malfunctions. 3. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 169	Continued From page 2 minutes and multiple soundings of the alarm. Interview with the maintenance technician at that same time confirmed that finding.	S 169		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs.	S 206	1. RN K and DA BB completed all mandatory training by 2/21/25. 2. The initial audit was completed on 2/19/2025 to review new hires within the last thirty days, with no identified staff missing education. An additional audit was conducted to review personal training for employees who were hired within the last six months and are still actively working for the facility. The identified staff who did not complete training within the 30-day window were given education. All education was completed by 2/28/25. 3. Education provided by DON and dietary manager to RN K and DA BB stating that education is required to be completed within 30 days for their job and must be done timely or disciplinary action can be taken. Education provided by the administrator to staff development and dietary manager regarding proper monitoring of new staff and the timeframe for completion of required topics. The newly hired staff will not be able to work after 30 days if they have not completed the mandatory training for their role. The administrator and HR director will conduct weekly audits for three weeks and then monthly for two months to ensure that new staff are hired and have their education assigned and completed within the first 30 days of hire.	2/28/2025

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S 206	Continued From page 3 This Administrative Rule of South Dakota is not met as evidenced by: Based on employee training records review, interview, and policy review, the provider failed to ensure mandatory training was provided on all the required training subjects for two of six sampled employees (K and BB). Findings include: 1. Review of registered nurse (RN) K's training records revealed: *She was hired on 12/2/24. *She had not received training during orientation regarding infection control and prevention. 2. Review of dietary aide (DA) BB's training records revealed: *She was hired on 8/31/24. *She had not received training during orientation regarding the following required topics: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Proper use of restraints. -Resident rights. -Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration needs of residents. -Abuse and neglect. 3. Interview on 1/30/25 at 3:06 p.m. with staff development coordinator H and administrator A revealed: *Staff development coordinator H assigned the required online training when staff were hired. *Administrator A expected that training to be completed within 30 days.	S 206	4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

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S 206	Continued From page 4 4. Interview on 1/30/25 at 4:12 p.m. with administrator A revealed: *He stated that DA BB had been working on her training. -He confirmed that she had completed the online training on confidentiality of resident information but had not completed any other required topic. *RN K had not completed the online training regarding infection control or prevention, but it had been reassigned to her for completion. 5. Review of the provider's revised 1/30/25 Orientation Policy revealed: *"Mandatory Compliance Training (Within the First 30 Days) -HIPPA & Resident Privacy -Resident Rights & Dignity -Elder Abuse, Neglect, & Exploitation Prevention -Infection Control & Prevention -Hand hygiene and standard precautions. -PPE usage (gloves, masks, gowns). -Bloodborne pathogen and exposure control. -COVID-19 and flu prevention protocols. -Fire Safety & Emergency Preparedness- -Fire drills and evacuation procedures. -Emergency response" *Employees who fail to complete the orientation within the required timeframe may be subject to disciplinary action, up to and including termination."	S 206		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable	S 210	1. The infection preventionist verified with assistant X that she filled out the form and that there were no identified communicable diseases for the staff member. 2. On 2/18/2025, an initial audit was completed for all new hires within the new year to ensure that they had the appropriate paperwork filled out for communicable diseases.	2/21/2025

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S 210	Continued From page 5 disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee records review, interview, and policy review, the provider failed to ensure the completion of a health evaluation within fourteen days of employment for one of six sampled employees (X). Findings include: 1. Review of certified nursing assistant X's employee records revealed: *She was hired on 10/7/24. *She completed her employee Communicable Disease Screening Form on 11/4/24. *That form was signed by a licensed health professional on 11/7/24. 2. Interview on 1/30/25 at 3:06 p.m. with staff development coordinator H and administrator A revealed: *Administrator A expected the employee health assessments to be completed within the required time frame. *There was no policy on the completion of the health assessment.	S 210	3. On 2/18/2025, the administrator educated the infection preventionist that all new hires will require a communicable disease form filled out with all the boxes appropriately checked. The form must also be completed within 14 days of the new hire's start date. The administrator and HR director will conduct weekly audits for three weeks and then monthly for two months to ensure any new hire completes the appropriate communicable disease form within 14 days of hire. 4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 210	Continued From page 6 3. Review of the provider's revised 1/30/25 Orientation Policy revealed it did not include the completion of a health assessment.	S 210		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on dietary employee training review, interview, and policy review the provider failed to ensure all the required dietary training topics had been provided within the required time frame for two of four sampled dietary employees (BB and CC). Findings include: 1. Review of the provider's employee file and training records on 1/30/25 revealed: *Dietary aide (DA) BB was hired on 8/31/24 and had not completed any of the required dietary training.	S 301	1. Staff member DA BB completed all required training by 2/19/25 and will not be allowed to work till completed. Staff member AC CC completed all the necessary topics by 1/29/25. 2. On 2/18/25, an initial audit of all the dietary staff was completed to ensure proper education, and no other staff members were identified as missing mandatory education. 3. The administrator provided education to the dietary manager on 2/18/2025. The dietary manager will review all the education topics required for completion within the first 30 days of the employee start date. If the education is past 30 days, the staff member will not be eligible to work until the required education is completed. The administrator will audit the process weekly for 3 weeks, then monthly for 2 months. 4. The IDT team (administrator, DON, ADON, or designees) will review initial and ongoing audits weekly. Audits will also be reviewed during the monthly QAPI meeting brought by the administrator. This meeting will determine when audits are discontinued.	2/21/2025

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S 301	Continued From page 7	S 301		

*Assistant cook (AC) CC was hired on 11/26/24 and completed the required trainings on 1/29/25, which was more than 30 days after hire.

2. Interview on 1/30/25 at 3:06 p.m. with staff development coordinator H and administrator A revealed:
*Staff development coordinator H assigned the required online training when staff were hired.
*Food services supervisor E tracked the completion of dietary training.
*Administrator A expected that training to be completed within 30 days.

Interview on 1/30/25 at 5:50 p.m. with food service supervisor E revealed:
*She oversaw and tracked the dietary training of the kitchen staff.
-About once a month the online training system sent a report of what training was due or past due.
*She confirmed that DA BB had not completed the required dietary training.
*She confirmed that AC CC completed her training yesterday (1/29/25).
*She confirmed the required dietary inservice training needed to be completed within 30 days of hire.

3. Review of the provider's revised 7/10/23 Dietary Services Policy revealed:
*"All dietary employees must complete initial and ongoing training to ensure compliance with state and federal regulations."
*"Training Requirements: New Employee Orientation (Within 30 Days of Hire)."
*" All new dietary employees must complete an orientation that covers:
-Food safety
-Hand washing

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 ______	01/30/2025

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 301	Continued From page 8 -Food handling and prep techniques -Foodborne illness -Serving and distribution procedures -Leftover food handling -Time and temp controls -Nutrition and hydration -sanitation."	S 301		

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 ______	01/28/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 on 1/28/25. Jenkin's Living Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]   TITLE: President/CEO   (X6) DATE: 2/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.