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 ______	09/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/20/22 through 9/22/22. Jenkin's Living Center was found not in compliance with the following requirements: F812 and F909.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, and policy review, the provider failed to ensure: *Two of three dishwasher ventilation ducts were maintained in a clean manner. *One of one food vending machine was cleaned. Findings include:	F 812	All ventilation ducts are scheduled to be cleaned by a professional duct cleaning company on 11/3/22. The dietary manager updated the cleaning schedule for duct cleaning on 9/22/22. All residents could potentially be affected by these findings. Dietary staff will be re-educated regarding cleaning procedure by 10/16/22 and the importance of storage, preparation and distribution of food according to professional standards for food service safety. The Registered Dietitian or designee will perform weekly audits of the cleaning schedule and cleanliness of the ducts weekly x4 and monthly x3. Results of these audits will be presented by the RD or designee to the monthly QAPI committee for review and recommendations. The vending machine was taken out of service on 9/22/22. The vending machine was cleaned on 10/4/22 and returned to service on 10/5/22. All residents could potentially be affected by these findings. Dietary staff were re-educated regarding the cleaning procedure and the importance of storage, preparation and distribution of food in accordance with professional standards for food service safety on 9/25/22. The Registered Dietitian or designee will perform audits of the cleaning schedule and cleanliness of the vending machine weekly x4 and monthly x3. Results will be reported by the RD or designee to the monthly QAPI meeting for review and recommendations.	11/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Gloe	Administrator	10/14/22

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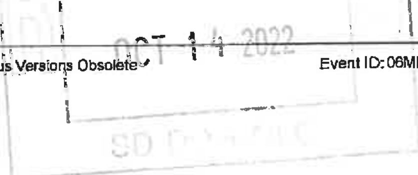

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F 812	Continued From page 1 1. Observation on 9/21/22 from 2:44 p.m. through 3:12 p.m. in the dietary department revealed the ventilation ducts above the dishwashers on the first and third floor kitchens were covered with dust and an unidentified black substance, which had the potential to fall from the duct onto clean dishes. Interview on 9/22/22 at 11:43 a.m. with maintenance supervisor C regarding the dishwasher ventilation ducts revealed: *He was not aware of the condition of the dishwasher ventilation ducts. *All the ventilation ducts throughout the building were cleaned on an annual basis. *A contracted ventilation duct cleaning service had cleaned the ventilation ducts on 2/6/22. *He agreed that the dishwasher ventilation ducts needed to be cleaned. 2. Observation on 9/21/22 at 3:02 p.m. of the rotating vending machine on "Main Street" of the facility revealed: *There were spots of white-colored fuzzy mold and black-colored mold and/or mildew throughout the inside and outside of the rotating vending machine. *Two plastic containers of hard boiled eggs were on the bottom shelf. -Both containers were broken due to being too large for the shelf space. -One of the hard boiled eggs was cracked and sitting directly on the shelf. *On the top shelf, there was a container of yogurt with spots of mold in the shelf space to the right of the yogurt. Interview on 9/21/22 at 3:12 p.m. with food	F 812		

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F 812	Continued From page 2 service supervisor D and assistant cook E regarding the rotating vending machine on Main Street revealed: *The morning shift employees were responsible for cleaning the rotating vending machine and rotating the food items in it. *The dietary department staff had not cleaned the rotating vending machine often because it took too long. *The rotating vending machine was mostly used by staff, but residents also had access to purchase food from it. *They did not: -Know when it had been cleaned last. -Have a cleaning schedule for the rotating vending machine. -Have documentation when it had been cleaned last. Review of the provider's undated Sanitation of Dietary Department policy revealed: *"Procedure: -1. The Dietary Manager shall record all cleaning and sanitation tasks for the department. -2. Tasks shall be designated to be the responsibility of specific positions in the department. -3. All tasks shall be addressed as to the frequency of cleaning. -4. The method of procedures to be used and agents used for cleaning shall be developed for each task or piece of equipment to be cleaned. -5. A cleaning schedule shall be posted weekly for all cleaning tasks, and employees will initial tasks as completed." Review of the dietary department's weekly Cleaning List revealed there was no task item to clean the rotating vending machine.	F 812		

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F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure positioning devices had a safety assessment completed for two of four sampled residents (1 and 10). Findings include: 1. Observation and interview with resident 10 on 9/20/22 at 4:41 p.m. in her room revealed she: *Had positioning rails on the top half of her bed on both the left and right sides. *Had asked for them to be installed. *Used them to reposition herself in bed. 2. Observation and interview with resident 1 on 9/21/22 at 9:04 a.m. in her room revealed she had: *Positioning rails on the top half of her bed on both the left and right sides. *The positioning rails as long as she could remember. *Used them all the time to reposition herself in bed. Interview on 9/21/22 at 2:41 p.m. with maintenance supervisor C regarding repositioning devices revealed: *Nursing staff would create a work order for	F 909	The Assistive Device Assessment used by Jenkins Living Center was re-written to include a safety assessment. A safety assessment was completed for residents 1 and 10 on 10/6/22. All residents who use assitive devices on their bed could potentially be affected by these findings. The MDS nurses were educated on 10/6/22 regarding the need to perform a safety assessment for residents who use assistive devices on their bed. DON or designee will audit residents who use assistive devices on their bed to ensure the Assistive Device Assessment includes a safety assessment. Audits will be completed weekly x4, then monthly x3. Results of these audits will be presented to the monthly QAPI committee for review and recommendations.	10/6/22

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F 909	Continued From page 4	F 909		

maintenance to put a positioning rail on a resident bed.
*The nursing department completed the quarterly assessments for the positioning rails.
*The assistive devices were ordered from the same company that manufactured the bed.
*He was not aware a safety assessment needed to be completed for positioning rails.

Interview on 9/21/22 at 3:43 p.m. with director of nursing B regarding repositioning devices revealed:
*If a resident needed/requested an assistive device a maintenance requisition was filled out.
*The nursing department completed an assistive device assessment/evaluation quarterly for residents who used them.
*She was not aware of any safety assessment that needed to be completed.

Interviews on 9/22/22 at 8:36 a.m. and at 10:40 a.m. with administrator A regarding repositioning devices revealed:
*He would check with the therapy department about a safety assessment.
*The nursing department completed a quarterly assessment for the positioning rails.
*He agreed the quarterly nursing assessment was different from the safety assessment that should have been completed by maintenance.

Review of the provider's April 2016 Assist Bar policy revealed:
*"Assist bar(s) may be utilized to assist residents with bed mobility and positioning if certain parameters are followed.
...Responsibility: RN/LPN/NA
-Instructions:
--1. An assessment on the resident must be done

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F 909	Continued From page 5 prior to installing assist bars. a. Assess for safety use and need for positioning and bed mobility assistance. --2. Notify the resident and/or family of the risk of entrapment, as indicated. --3. If the resident is assessed to be safe, the need for assistance exists and the resident/family has been informed of the risk(s), call the attending physician for an order."	F 909		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 9/20/22 through 9/22/22. Jenkin's Living Center was found in compliance.	E 000		

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Scott Gloe	Administrator	10/14/22

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OCT 14 2022

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	435036	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/21/2022

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/21/22. Jenkin's Living Center (building 02) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 9/22/22. Please mark an F in the completion date column for K225 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K223, K345, and K916 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	K 223		

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Scott Gloe	Administrator	10/14/22

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K 223	Continued From page 1 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain one of six hazardous areas (lost and found/new linen room) in building one as required. Findings include: 1. Observation on 9/21/22 at 9:00 a.m. revealed the lost and found/new linen room in the basement was greater than 100 square feet and contained combustible items. The corridor doors were not equipped with a closers, and were blocked open by two carts. Interview with the maintenance director at the time of the observation confirmed that finding. He was not aware these doors protected a hazardous areaa. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 223	The lost and found/linen room has been equipped with a door closure on 10/6/22 Facility residents were not impacted by the findings of this deficiency The Director of Maintenance provided education to the maintenance and laundry staff on 10/12/22 to be sure the door remains closed The Director of Maintenance or designee will audit the door weekly x4 and monthly x3 to ensure the door is working properly. The Director of Maintenance or designee will report audit results at the monthly QAPI meetings for review and recommendations	10/12/22
K 225 SS=D	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

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K 225	Continued From page 2 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 9/21/22 at 9:30 a.m. revealed the west stair connecting the first and second level was not provided with a landing at the second level. Record review of previous survey data confirmed the landing was not provided at the second level. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.	K 225		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to test the fire alarm system as required (listing of devices with locations and test results) for calender year 2022. Findings include: 1. Document review on 9/21/22 at 3:00 p.m. revealed device test results (alarm initiating, supervisory alarm initiating, and notification) did not provide an itemized list with the following	K 345		

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K 345	Continued From page 3 information, device type, address, location, and test result as required. There was only a summary list of notification and activation devices provided for test results. The maintenance supervisor was present when the deficiency was identified. 2. Included within the annual testing report was the comment "some horns and strobes aren't working", however no specific devices were noted as required. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency all notification and detection devices of the fire alarm system. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 345	Fire alarm test was conducted on 10/7/22. Some strobes and alarms were not working properly. Fire Alarm Co. will test alarm annually and provide itemized list of device type, address, location and test results as required of Fire alarm testing requirements. New strobes and alarms have been ordered and will be installed upon arrival. All facility residents are impacted by the findings of this deficiency. The director of maintenance provided education to maintenance staff on monitoring the strobes and alarms on 10/7/22 The Director of Maintenance or designee will audit fire alarm strobes and alarms for a period of 3 months to ensure strobes and alarms are working properly. The Director of Maintenance or designee will report audit results at the monthly QAPI meetings for review and recommendations.	11/11/22
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and	K 916	The Cummins generator annunciator panel that is mounted on second floor building 2 nurses station will be moved to building 2 third floor nurses station on 10/12/22 where it can be monitored at all times. All facility residents are impacted by the findings of this deficiency The director of maintenance provided education to nursing and maintenance staff on 10/12/22 regarding the new location of the annunciator panel. The Director of Maintenance or designee will audit the annunciator panel for proper working order weekly x4 and monthly x3. The Director of Maintenance or designee will report audit results at monthly QAPI committee meetings for review and recommendations	10/12/22

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K 916	Continued From page 4 interview the provider failed to maintain a remote alarm in a continuously occupied location (Cummins generator annunciator). Findings include: 1. Observation on 9/21/22 at 10:00 a.m. revealed the Cummins generator annunciator was mounted in the building 2 second floor patient nurses' station. The second floor patient wing was unoccupied as staff and residents have been moved to third floor. Interview with the maintenance technician at the time of the observation confirmed those findings. This deficiency has the potential to affect 100% of the occupants of the building.	K 916		

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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 **02 - BUILDING 02** B. WING ____________	**09/21/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/21/22. Jenkin's Living Center (building 2) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 9/22/22. Please mark an F in the completion date column for K225 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K345, and K916 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=E	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider	K 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Gloe	Administrator	10/14/22

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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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	**09/21/2022**

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 226	Continued From page 1 failed to maintain the fire-resistive design of one of one horizontal exit and building separation wall (between the building four and building two). Findings include: 1. Observation on 9/21/22 at 10:50 a.m. revealed the two-hour, fire-rated separation wall between the building four and building two on first floor had a ninety-minute, fire-rated metal door did not have a latch. The latching mechanism had been removed. Interview at the time of observation with the maintenance supervisor confirmed that condition. He did not know what had happened to the latching mechanism. The deficiency could affect 100% of the occupants of the smoke compartments.	K 226	The latch on the two hour, fire-rated seperation wall between building four and building two was replaced on 10/6/22. All facility residents could be impacted by this deficiency. The Director of Maintenance provided education to maintenance staff on 10/6/22 to be sure the latch remains in place The Director of Maintenance or designee will audit the latch weekly x4 and monthly x3 to ensure the latch is in place. The Director of Maintenance or designee will report audit results at the monthly QAPI meetings for review and recommendations	10/6/22
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to test the fire alarm system as required (listing of devices with locations and test results) for calender year 2022. Findings include:	K 345	Fire alarm test was conducted on 10/7/22. Some strobes and alarms were not working properly. Fire Alarm Co. will test alarm annually and provide itemized list of device type, address, location and test results as required of fire alarm testing requirements. New strobes and alarms have been ordered and will be installed upon arrival. All facility residents are impacted by the findings of this deficiency. The director of maintenance provided education to maintenance staff on monitoring the strobes and alarms on 10/7/22 The director of maintenance or designee will audit fire alarm strobes and alarms for a period of 3 months to ensure strobes and alarms are working properly. The director of maintenance or designee will report audit results at the monthly QAPI meetings for review and recommendations.	11/11/22

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 **02 - BUILDING 02** B. WING	**09/21/2022**

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 345	Continued From page 2 1. Document review on 9/21/22 at 3:00 p.m. revealed device test results (alarm initiating, supervisory alarm initiating, and notification) did not provide an itemized list with the following information, device type, address, location, and test result as required. There was only a summary list of notification and activation devices provided for test results. The maintenance supervisor was present when the deficiency was identified. 2. Included within the annual testing report was the comment "some horns and strobes aren't working", however no specific devices were noted as required. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency all notification and detection devices of the fire alarm system. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 345		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.	K 916	The Cummins generator annunciator panel that is mounted on second floor building 2 nurses station will be moved to building 2 third floor nurses station on 10/12/22 where it can be monitored at all times. All facility residents are impacted by the findings of this deficiency The director of maintenance provided education to nursing and maintenance staff on 10/12/22 regarding the new location of the annunciator panel. The director of maintenance or designee will audit the annunciator panel for proper working order weekly x4 and monthly x3. The director of maintenance or designee will report audit results at the monthly QAPI committee meetings for reivew and recommendations.	10/12/22

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 02 - BUILDING 02 B. WING	09/21/2022

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 916	Continued From page 3 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the provider failed to maintain a remote alarm in a continuously occupied location (Cummins generator annunciator). Findings include: 1. Observation on 9/21/22 at 10:00 a.m. revealed the Cummins generator annunciator was mounted in the building 2 second floor patient nurses' station. The second floor patient wing was unoccupied as staff and residents have been moved to third floor. Interview with the maintenance technician at the time of the observation confirmed those findings. This deficiency has the potential to affect 100% of the occupants of the building.	K 916		

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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 **03 - BUILDING 03** B. WING ________	**09/21/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/21/22. Jenkin's Living Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K223, K345 and K916 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain two of four hazardous areas in building three (receiving/trash room and storage room number 87) as required. Findings include:	K 223	The receiving/trash room has been equipped with a closer and room 87 has been adjusted so the door closes and latches properly. Both doors were properly fixed on 10/6/22. Facility residents were not impacted by the findings of this deficiency. The Director of Maintenance provided education to the maintenance staff on 10/12/22 to be sure doors close and latch properly. The Director of Maintenance or designee will audit the doors weekly x4 and monthly x3 to ensure the door closure and latching mechanism are working properly. The Director of Maintenance or designee will report audit results at the monthly QAPI meetings for review and recommendations.	10/12/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Gloe	Administrator	10/14/22

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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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 ______	09/21/2022

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 223	Continued From page 1 1. Observation on 9/21/22 at 11:05 a.m. revealed the receiving/trash room was greater than 100 square feet and contained combustible items. The corridor door was not equipped with a closer as required. 2. Observation on 9/21/22 at 11:20 a.m. revealed the storage room numbered 87 was greater than 100 square feet and contained combustible items. The door would not close and latch as required. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 223		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to test the fire alarm system as required (listing of devices with locations and test results) for calender year 2022. Findings include: 1. Document review on 9/21/22 at 3:00 p.m.	K 345	Fire alarm test was conducted on 10/7/22. Some strobes and alarms were not working properly. Fire Alarm Co. will test alarm annually and provide itemized list of device type, address, location and test results as required of Fire alarm testing requirements. New strobes and alarms have been ordered and will be installed upon arrival. All facility residents are impacted by the findings of this deficiency The Director of Maintenance provided education to maintenance staff on monitoring the strobes and alarms on 10/7/22. The Director of Maintenance or designee will audit fire alarm strobes and alarms for a period of 3 months to ensure strobes and alarms are working properly. The Director of Maintenance or designee will report audit results at the monthly QAPI meetings for review and recommendations.	11/11/22

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 03 - BUILDING 03 B. WING ______	09/21/2022

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 345	Continued From page 2 revealed device test results (alarm initiating, supervisory alarm initiating, and notification) did not provide an itemized list with the following information, device type, address, location, and test result as required. There was only a summary list of notification and activation devices provided for test results. The maintenance supervisor was present when the deficiency was identified. 2. Included within the annual testing report was the comment "some horns and strobes aren't working", however no specific devices were noted as required. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency all notification and detection devices of the fire alarm system. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 345		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	K 916	The Cummins generator annunciator panel that is mounted on second floor building 2 nurses station will be moved to building 2 third floor nurses station on 10/12/22 where it can be monitored at all times. All facility residents are impacted by the findings of this deficiency. The Director of Maintenance provided education to nursing and maintenance staff on 10/12/22 regarding the new location of the annunciator panel. The Director of Maintenance or designee will audit the annunciator panel for proper working order weekly x4 and monthly x3. The Director of Maintenance or designee will report audit results at monthly QAPI committee meetings for review and recommendations.	10/12/22

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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 03 - BUILDING 03 B. WING ________	09/21/2022

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 916	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the provider failed to maintain a remote alarm in a continuously occupied location (Cummins generator annunciator). Findings include: 1. Observation on 9/21/22 at 10:00 a.m. revealed the Cummins generator annunciator was mounted in the building 2 second floor patient nurses' station. The second floor patient wing was unoccupied as staff and residents have been moved to third floor. Interview with the maintenance technician at the time of the observation confirmed those findings. This deficiency has the potential to affect 100% of the occupants of the building.	K 916		

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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 ______	09/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/21/22. Jenkin's Living Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K225, K345 and K916 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=E	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire-resistive design of one of one horizontal exit and building separation wall (between the building four and building two). Findings include: 1. Observation on 9/21/22 at 10:50 a.m. revealed the two-hour, fire-rated separation wall between the building four and building two on first floor had a ninety-minute, fire-rated metal door did not	K 226	The latch on the two hour, fire rated seperation wall between building four and building two was replaced on 10/6/22. All facility residents could be impacted by the findings of this deficiency. The Director of Maintenance provided education to maintenance staff on 10/6/22 to be sure the latch remains in place. The Director of Maintenance or designee will audit the latch weekly x4 and monthly x3 to ensure the latch is in place. The Director of Maintenance or designee will report audit results at the monthly QAP meetings for review and recommendations.	10/6/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Gloe	Administrator	10/14/22

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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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 ____	**09/21/2022**

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 226	Continued From page 1 have a latch. The latching mechanism had been removed. Interview at the time of observation with the maintenance supervisor confirmed that condition. He did not know what had happened to the latching mechanism. The deficiency could affect 100% of the occupants of the smoke compartments.	K 226		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to test the fire alarm system as required (listing of devices with locations and test results) for calender year 2022. Findings include: 1. Document review on 9/21/22 at 3:00 p.m. revealed device test results (alarm initiating, supervisory alarm initiating, and notification) did not provide an itemized list with the following information, device type, address, location, and test result as required. There was only a summary list of notification and activation devices provided for test results. The maintenance supervisor was present when the deficiency was	K 345	Fire alarm test was conducted on 10/7/22. Some strobes and alarms were not working properly. Fire Alarm Co. will test alarm annually and provide itemized list of device type, address, location and test results as required of Fire alarm testing requirements. New strobes and alarms have been ordered and will be installed upon arrival. All facility residents are impacted by the findings of this deficiency. The Director of Maintenance provided education to maintenance staff on monitoring strobes and alarms on 10/7/22. The Director of Maintenance or designee will audit fire alarm strobes and alarms for a period of 3 months to ensure strobes and alarms are working properly. The Director of Maintenance or designee will report audit results at the monthly QAPI meetings for review and recommendations.	11/11/22

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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 ______	09/21/2022

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 345	Continued From page 2 identified. 2. Included within the annual testing report was the comment "some horns and strobes aren't working", however no specific devices were noted as required. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency all notification and detection devices of the fire alarm system. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 345		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the provider failed to maintain a remote alarm in a continuously occupied location (Cummins generator annunciator). Findings include:	K 916	The Cummins generator annunciator panel that is mounted on second floor building 2 nurses station will be moved to building 2 third floor nurses station on 10/12/22 where it can be monitored at all times. All facility residents could be impacted by this deficiency. The Director of Maintenance provided education to nursing and maintenance staff on 10/12/22 regarding the new location of the annunciator. The Director of Maintenance or designee will audit the annunciator panel for proper working order weekly x4 and monthly x3. The Director of Maintenance or designee will report audit results at the monthly QAPI committee meetings for review and recommendations.	10/12/22

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 05 - BUILDING 05 B. WING	09/21/2022

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	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to test the fire alarm system as required (listing of devices with locations and test results) for calender year 2022. Findings include: 1. Document review on 9/21/22 at 3:00 p.m. revealed device test results (alarm initiating, supervisory alarm initiating, and notification) did not provide an itemized list with the following information, device type, address, location, and test result as required. There was only a summary list of notification and activation devices provided for test results. The maintenance supervisor was present when the deficiency was identified. 2. Included within the annual testing report was the comment "some horns and strobes aren't working", however no specific devices were noted as required. Failure to test the fire alarm system as required	K 345	Fire alarm test was conducted on 10/7/22. Some strobes and alarms were not working properly. Fire Alarm Co. will test alarm annually and provide itemized list of device type, address, location and test results as required of Fire alarm testing requirements. New strobes and alarms have been ordered and will be installed upon arrival. All facility residents are impacted by the findings of this deficiency. The Director of Maintenance provided education to maintenance staff on monitoring strobes and alarms on 10/7/22 The Director of Maintenance or designee will audit fire alarm strobes and alarms for a period of 3 months to ensure strobes and alarms are working properly. The Director of Maintenance or designee will report audit results at the monthly QAPI meetings for review and recommendations.	11/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Gloe	Administrator	10/14/22

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.

OCT 14 2022

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	09/21/2022

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 916	Continued From page 3 1. Observation on 9/21/22 at 10:00 a.m. revealed the Cummins generator annunciator was mounted in the building 2 second floor patient nurses' station. The second floor patient wing was unoccupied as staff and residents have been moved to third floor. Interview with the maintenance technician at the time of the observation confirmed those findings. This deficiency has the potential to affect 100% of the occupants of the building.	K 916		

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 05 - BUILDING 05 B. WING ______	09/21/2022

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 345	Continued From page 1 increases the risk of death or injury due to fire. The deficiency all notification and detection devices of the fire alarm system. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 345		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the provider failed to maintain a remote alarm in a continuously occupied location (Cummins generator annunciator). Findings include: 1. Observation on 9/21/22 at 10:00 a.m. revealed the Cummins generator annunciator was mounted in the building 2 second floor patient nurses' station. The second floor patient wing was unoccupied as staff and residents have been moved to third floor. Interview with the maintenance technician at the	K 916		

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 05 - BUILDING 05 B. WING ______	09/21/2022

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 916	Continued From page 2 time of the observation confirmed those findings. This deficiency has the potential to affect 100% of the occupants of the building.	K 916		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10703	A. BUILDING: ____ B. WING ____	09/22/2022

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

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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 9/20/22 through 9/22/22. 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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/20/22 through 9/22/22. Jenkin's Living Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Gloe	Administrator	10/14/22