PRINTED: 10/04/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435036	B. WNG			09/	22/2022
	ROVIDER OR SUPPLIER			21	TREET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH MAPLE STREET VATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 812	with 42 CFR Part 483 for Long Term Care fa 9/20/22 through 9/22/ was found not in com- requirements: F812 a	h survey for compliance , Subpart B, requirements acilities, was conducted from 22. Jenkin's Living Center pliance with the following nd F909. ore/Prepare/Serve-Sanitary	F.	312	. All ventilation ducts are scheduled to be clea	aned by a	
SS=E	CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must -	2)			professional duct cleaning company on 11/3 dietary manager updated the cleaning scheduct cleaning on 9/22/22. All residents could potentially be affected by findings.	/22. The fulle for	11/11/22
2.5	§483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regulation of the provision doe facilities from using progradens, subject to consider growing and food (iii) This provision doe from consuming foods (iii) This provision doe food in accordant standards for food set This REQUIREMENT by: Based on observation review, and policy review, and policy review, and policy reviews and p	ed satisfactory by federal, es. cod items obtained directly subject to applicable State alations. It is not prohibit or prevent roduce grown in facility ompliance with applicable dishandling practices. It is not procured by the facility. It is not met as evidenced in, interview, document riew, the provider failed to sher ventilation ducts were manner.			Dietary staff will be re-educated regarding of procedure by 10/16/22 and the importance of preparation and distribution of food according professional standards for food service safe. The Registered Dietitian or designee will perweekly audits of the cleaning schedule and cleanliness of the ducts weekly x4 and month Results of these audits will be presented by designee to the monthly QAPI committee for and recommendations. The vending machine was taken out of ser 9/22/22. The vending machine was cleane 10/4/22 and returned to service on 10/5/22. All residents could potentially be affected be findings. Dietary staff were re-educated regarding the cleaning procedure and the importance of storage, preparation and distribution of fraccordance with professional standards for service safety on 9/25/22. The Registered Dietitian or designee will paudits of the cleaning schedule and cleanling the vending machine weekly x4 and month Results will be reported by the RD or designee monthly QAPI meeting for review and recommendations.	or storage g to y. If the RD or review Vice on ad on review y these of the RD of received on the RD of rece	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE Administrator		(X6) DATE 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Scott Gloe

Event ID: 06MF11

SD Farancia

Facility ID: 0013

If continuation sheet Page 1 of 6

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		435036	B. WING_			09/22/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	Continued From page	2 1	F8	12		
	3:12 p.m. in the dieta ventilation ducts above first and third floor kith dust and an unidentificated had the potential to fadishes. Interview on 9/22/22 maintenance supervision of the was not aware or dishwasher ventilation and the ventilation and the ventilation of the ventilation of the ventilation of the inside and outside machine. *Two plastic containers were large for the shelf spanned in the ventilation of the yogurt.	sor C regarding the n ducts revealed: If the condition of the n ducts. If the condition of the n ducts. It is condition of the building annual basis. It is conduct cleaning service is lation ducts on 2/6/22. It is hwasher ventilation ducts of the lation of the lation on "Main Street" of the lation of the lati				

PRINTED: 10/04/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER JENKIN'S LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (K4) 10 PREFIX TAG COntinued From page 2 service supervisor D and assistant cook E regarding the rotating vending machine and rotating by ending machine often because it took too long. "The dictary 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. "The dictary department that had been cleaned last. -Have a cleaning schedule for the rotating vending wending to purchase food from it. "They did not: -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		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	PLE CONSTRUCTION IG	_	COMPLETED
JENKIN'S LIVING CENTER 215 SOUTH MAPLE STREET WATERTOWN, SD 57201			435036	B. WING_		_	09/22/2022
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 2 service supervisor D and assistant cook E regarding the rotating vending machine and rotating the food items in it. "The morning shift employees were responsible for cleaning the rotating vending machine and rotating vending machine often because it took too long. "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:					215 SOUTH MAPLE STR	REET	
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 lastHave a cleaning schedule for the rotating vending machineHave 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORF	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT	COMPLETION
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	service supervisor D regarding the rotating Street revealed: *The morning shift en for cleaning the rotati rotating the food item *The dietary departm rotating vending mac too long. *The rotating vending by staff, but residents purchase food from it *They did not: -Know when it had be -Have a cleaning sch vending machineHave documentation last. Review of the provide Dietary Department p *"Procedure: -1. The Dietary Mana and sanitation tasks if -2. Tasks shall be de responsibility of spec department3. All tasks shall be if frequency of cleaning -4. The method of pro agents used for clear each task or piece of -5. A cleaning schedu all cleaning tasks, an as completed." Review of the dietary Cleaning List revealed	and assistant cook E I vending machine on Main Inployees were responsible Ing vending machine and Is in it. In ent staff had not cleaned the Inhine often because it took I machine was mostly used I also had access to I also had access to I also had been cleaned I when it had been cleaned I are sundated Sanitation of I another the rotating I a when it had been cleaned I are shall record all cleaning I are the department. I signated to be the I addressed as to the I addressed and and an	F	12		

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA SUBSTITUTE STATE STA			CONSTRUCTION	(X3) DATE S COMPL	
		435036	B. WING	- 50		09/2	2/2022
	ROVIDER OR SUPPLIER			21	REET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH MAPLE STREET VATERTOWN, SD 57201 PROVIDER'S PLAN OF CORRECTION	v .	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
	bed frames, mattress part of a regular mai areas of possible en and mattresses are separately from the ensure that the bed frame are compatible. This REQUIREMEN by: Based on observation review, the provider devices had a safety two of four sampled Findings include: 1. Observation and 9/20/22 at 4:41 p.m. *Had positioning rai on both the left and *Had asked for ther *Used them to repo 2. Observation and 9/21/22 at 9:04 a.m. had: *Positioning rails or both the left and rig. *The positioning rai remember. *Used them all the bed. Interview on 9/21/2 maintenance super devices revealed:	act Regular inspection of all ses, and bed rails, if any, as intenance program to identify trapment. When bed rails used and purchased bed frame, the facility must rails, mattress, and bed e. T is not met as evidenced on, interview, and policy failed to ensure positioning assessment completed for residents (1 and 10). interview with resident 10 on in her room revealed she; is on the top half of her bed right sides. In to be installed, sition herself in bed. in the top half of her bed on hit sides. It is as long as she could time to reposition herself in	F	909	The Assistive Device Assessment used Living Center was re-written to include assessment. A safety assessment was for residents 1 and 10 on 10/6/22. All residents who use assitive devices could potentially be affected by these fill. The MDS nurses were educated on 10/regarding the need to perform a safety for residents who use assistive devices. DON or designee will audit residents who assistive devices on their bed to ensure Assistive Device Assessment includes assessment. Audits will be completed then monthly x3. Results of these audit presented to the monthly QAPI commit and recommendations.	a safety completed in their bed indings. 6/22 assessment on their bed in use the a safety weekly x4, is will be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IΩENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET		OMPLETED	
		435036	B. WING_			09/22/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 909	bed. *The nursing departmassessments for the the same company that in the was not aware at the bed completed for purising B regarding in revealed: *If a resident needed device a maintenance the nursing department device assessment/eresidents who used the the was not aware that needed to be confused to be confused to the confused to the with about a safety assess. *The nursing departmassessment for the partmassessment for the partma	positioning rail on a resident ment completed the quarterly positioning rails. Is were ordered from the manufactured the bed. Is safety assessment needed iositioning rails. In at 3:43 p.m. with director of repositioning devices Irrequested an assistive re requisition was filled out. In an assistive re requisition quarterly for them. In any safety assessment Impleted. If at 8:36 a.m. and at 10:40 In at Regarding repositioning In the therapy department Is ment completed a quarterly In a safety assessment In a safety assessm	F 96	09		

TATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		435036	B. WING		09/22/2022
	ROVIDER OR SUPPLIER		21	REET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTH MAPLE STREET ATERTOWN, SD 57201	
(X4) ID PREFIX TAG	/EACH DESIGNO	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL BUSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 909	positioning and bed I2. Notify the reside entrapment, as indic	ist bars. ty use and need for mobility assistance. nt and/or family of the risk of ated. assessed to be safe, the exists and the resident/family of the risk(s), call the	F 909		

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STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY	
		435036	B. WING			09/	22/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE; ZIP CO 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
E 000	CFR Part 482, Subpa Emergency Prepared Term Care Facilities, through 9/22/22. Jenk found in compliance.	ey for compliance with 42 rt B, Subsection 483.73, ness, requirements for Long was conducted from 9/20/22 tin's Living Center was		TITLE			(X6) DATE
Coott Clas	SHESTONG OIL LINGSIDEING	e, , service receipment o didital		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.

Scott Gloe

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		435036	B. WING		8	09/21/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 000		ey for compliance with the 2) (2012 existing health care	K	000			
	occupancy) was cond Living Center (building	ucted on 9/21/22. Jenkin's g 02) was found not in FR 483.90 (a) requirements					
	2012 LSC for existing	the requirements of the health care occupancies valuation System (FSES)					
		ne completion date column identified as meeting the					
13	2012 LSC for existing upon correction of the K223, K345, and K916	the requirements of the health care occupancies deficiencies identified at 3 in conjunction with the it to continued compliance ndards.					
K 223 SS=D	Doors with Self-Closic CFR(s): NFPA 101	ig Devices	К2	23			
	or horizontal exit, smo area enclosure are se closed position, unless device complying with closes all such doors to compartment or entire * Required manual fire * Local smoke detectors	ageway, stainway enclosure, ske barrier, or hazardous lf-closing and kept in the sheld open by a release 7.2.1.8.2 that automatically throughout the smoke facility upon activation of: e alarm system; and ors designed to detect the the opening or a required					
ABODATODY		UPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

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.

FORM CMS-2567(02-99) Previous Versions Obsolete OCT 14 202 Event ID: 06MF2

Scott Gloe

Facility ID: 0013

Administrator

If continuation sheet Page 1 of 5

10/14/22

STATEMENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIÀ IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01	(X3) DATE S COMPL	ETED
		435036	B. WING			09/2	1/2022
NAME OF DR	OVIDER OR SUPPLIER	430036	D. VIIITO	ST	REET ADDRESS, CITY, STATE, ZIP CODE	00.2	
					5 SOUTH MAPLE STREET		
JENKIN'S I	IVING CENTER			W	ATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
· · · · · · · · · · · · · · · · · · ·	* Loss of power. 18.2.2.2.7, 18.2.2.2.3. This REQUIREMEN' by: Based on observation and found/new linen required. Findings in 1. Observation on 9/ the lost and found/ne basement was great contained combustif were not equipped with blocked open by two linterview with the mitime of the observations areas. The deficiency had	system, if installed; and 3, 19.2.2.2.7, 19.2.2.2.8 T is not met as evidenced on and interview, the provider e of six hazardous areas (lost room) in building one as iclude: 21/22 at 9:00 a.m. revealed ew linen room in the ser than 100 square feet and ole items. The corridor doors with a closers, and were o carts. aintenance director at the ion confirmed that finding. He e doors protected a the potential to affect 100% of at smoke compartment.		223	The lost and found/linen room has been equivith a door closure on 10/6/22 Facility residents were not impacted by the this deficiency The Director of Maintenance provided educing maintenance and laundry staff on 10/12/22 the door remains closed The Director of Maintenance or designee with door weekly x4 and monthly x3 to ensure the door is working properly. The Director of Me or designee will report audit results at the minimum QAPI meetings for review and recommended.	ation to the to be sure If audit the e internance contriv	10/12/22
	exits are in accorda	keproof enclosures used as			27		
	by:	NT is not met as evidenced tion and record review, the					

PRINTED: 10/04/2022 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 435036 B. WING 09/21/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 215 SOUTH MAPLE STREET JENKIN'S LIVING CENTER WATERTOWN, SD 57201 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 225 Continued From page 2 K 225 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 345 Fire Alarm System - Testing and Maintenance K 345 CFR(s): NFPA 101 SS=F 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

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O	CONSTRUCTION - MAIN BUILDING 01	(X3) DATE S COMPL	
		435036	B. WING		09/2	1/2022
	ROVIDER OR SUPPLIER LIVING CENTER SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	218	REET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTH MAPLE STREET ATERTOWN, SD 57201 PROVIDER'S PLAN OF CORRECEACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETIO DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
K 345	test result as require summary list of notification provided for test result supervisor was presultentified. 2. Included within the the comment "some working", however nas required. Failure to test the first increases the risk of	ype, address, location, and d. There was only a cation and activation devices ults. The maintenance ent when the deficiency was annual testing report was horns and strobes aren't o specific devices were noted a death or injury due to fire.	K 345	Fire alarm test was conducted on 1 strobes and alarms were not working Fire Alarm Co. will test alarm annulatemized list of device type, address test results as required of Fire alarm requirements. New strobes and alardered and will be installed upon a All facility residents are impacted by this deficiency. The director of maintenance provion maintenance staff on monitoring tha alarms on 10/7/22 The Director of Maintenance or defire alarm strobes and alarms for a months to ensure strobes and alar properly. The Director of Maintena will report audit results at the monthmeetings for review and recommendations.	ng properly. ally and provide s, location and n testing rms have been arrival. y the findings of led education to e strobes and signee will audit period of 3 ms are working nce or designee hiv QAPI	11/11/22
K 916 SS=F	2010 NFPA 72 Sect Section 7.12-7.14 a Electrical Systems - CFR(s): NFPA 101 Electrical Systems - Alarm Annunciator A remote annunciat powered is provided generating personne hard-wired to indical emergency powers system (e.g., building to be substituted for 6.4.1.1.17, 6.4.1.1.1 This REQUIREMENTS	Essential Electric System Essential Electric System or that is storage battery d to operate outside of the a location readily observed by I. The annunciator is the alarm conditions of the source. A centralized computer ing information system) is not in the alarm annunciator.	K 916	The Cummins generator annunciate mounted on second floor building 2 will be moved to building 2 third floor on 10/12/22 where it can be monito All facility residents are impacted by this deficiency The director of maintenance provid nursing and maintenance staff on 1 the new location of the annunciator. The Director of Maintenance or desthe annunciator panel for proper wweekly x4 and monthly x3. The Director designee will report monthly QAPI committee meetings recommendations	nurses station red at all times. y the findings of the findings of the office of the	

PRINTED: 10/04/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION I - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
		435036	B. WNG		<u> </u>	09/	21/2022
	ROVIDER OR SUPPLIER			21	TREET ADDRESS, CITY, STATE, ZIP ÇODE 15 SOUTH MAPLE STREET VATERTOWN, SD 67201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
K 916	alarm in a continuous (Cummins generator include: 1. Observation on 9/2 the Cummins general mounted in the buildin nurses' station. The swas unoccupied as simoved to third floor. Interview with the matime of the observation.	failed to maintain a remote ly occupied location annunciator). Findings 1/22 at 10:00 a.m. revealed for annunciator was ag 2 second floor patient econd floor patient wing aff and residents have been intenance technician at the in confirmed those findings.	K	916			

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NOF CORRECTION DENTIFICATION NUMBER: A. BUILDING 02 - BUILDING 02				TE SURVEY	
		435036	B. WING			9/21/2022
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	3	K	000		
SS=E	Life Safety Code (LS occupancy) was concliving Center (buildin compliance with 42 of for Long Term Care in the building will mee 2012 LSC for existing and the Fire Safety Edated 9/22/22. Please mark an F in for K225 deficiencies FSES. The building will mee 2012 LSC for existing upon correction of the K345, and K916 in commitment to continuous safety standards. Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if us 7.2.4 and the provisi 18.2.2.5.7, or 19.2.2 18.2.2.5. This REQUIREMEN by: Based on observations.	the requirements of the ghealth care occupancies evaluation System (FSES) the completion date column identified as meeting the ghealth care occupancies the deficiencies identified at onjunction with the provider's mued compliance with the fire sed, are in accordance with those of 18.2.2.5.1 through .5.1 through 19.2.2.5.4.		226		OS DATE
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE Administrator		(X6) DATE 1 0/14/22

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Scott Gloe

Event ID: 06MF21

Facility ID: 0013

If continuation sheet Page 1 of 4

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 2 - BUILDING 02	(X3) DATE :	SURVEY LETED
		435036	B. WING		09/2	21/2022
	ROVIDER OR SUPPLIER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH MAPLE STREET MATERTOWN, SD 57201		5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	failed to maintain the of one horizontal exit (between the building Findings include: 1. Observation on 9/2 the two-hour, fire-rate the building four and a ninety-minute, fire-rhave a latch. The late removed. Interview at the time maintenance superview at the time maintenance superview and did not know what latching mechanism. The deficiency could occupants of the smoofire Alarm System - CFR(s): NFPA 101 Fire Alarm System - A fire alarm system is accordance with an awith the requirements Electric Code, and Nand Signaling Code. acceptance, maintenavailable. 9.6.1.3, 9.6.1.5, NFP This REQUIREMENT by: Based on observation failed to test the fire service of the suid of the of	fire-resistive design of one and building separation wall four and building separation wall four and building two). 21/22 at 10:50 a.m. revealed ed separation wall between building two on first floor had rated metal door did not ching mechanism had been of observation with the sor confirmed that condition. It had happened to the affect 100% of the oke compartments. Testing and Maintenance Testing and Maintenance Is tested and maintained in approved program complying is of NFPA 70, National Fire Alarm Records of system ance and testing are readily. A 70, NFPA 72 T is not met as evidenced on and interview, the provider clarm system as required the locations and test results)	K 226	The latch on the two hour, fire-rated sepe between building four and building two was on 10/6/22. All facility residents could be impacted by deficiency. The Director of Maintenance provided edimaintenance staff on 10/6/22 to be sure the remains in place. The Director of Maintenance or designee latch weekly x4 and monthly x3 to ensure tatch is in place. The Director of Maintenadesignee will report audit results at the mineetings for review and recommendation for the provided list of device type, address, locat test results as required of fire alarm testin requirements. New strobes and alarms had ordered and will be installed upon arrival. All facility residents are impacted by the fithis deficiency. The director of maintenance provided edumaintenance staff on monitoring the strobalarms on 10/7/22. The director of maintenance or designee fire alarm strobes and alarms for a period months to ensure strobes and alarms are properly. The director of maintenance or designee fire alarm strobes and alarms are properly. The director of maintenance or designee fire alarm strobes and alarms are properly. The director of maintenance or designee fire alarm strobes and alarms are properly. The director of maintenance or designee fire alarm strobes and alarms are properly. The director of maintenance or designee fire alarm strobes and alarms are properly. The director of maintenance or designee fire alarm strobes and alarms for a period months to ensure strobes and alarms for a period months to ensure strobes and alarms are properly. The director of maintenance or designee fire alarm strobes and alarms for a period months to ensure strobes and alarms for a period months to ensure strobes and alarms for a period months to ensure strobes and alarms for a period month alarms are properly. The director of maintenance or designee fire alarm strobes and alarms for a period month alarms for a period	this ucation to ne latch will audit the the ance or onthly QAPI of provide ion and grave been are and will audit of 3 working designee.	11/11/22

STATEMENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02		(X3) DATE SURVEY COMPLETED	
		435036	B. WING		09/21/2022	
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
K 916	revealed device test supervisory alarm init not provide an itemiz information, device ty test result as requires summary list of notifiprovided for test result as present identified. 2. Included within the the comment "some working", however not as required. Failure to test the first increases the risk of The deficiency all not devices of the fire also Ref. 2012 NFPA 101 2010 NFPA 72 Section 7.12-7.14 are Electrical Systems - CFR(s): NFPA 101 Electrical Systems - Alarm Annunciator A remote annunciator A remote annunciator and powered is provided generating personnel hard-wired to indicate emergency power system (e.g., building the summary in the system (e.g., building information in the syst	on 9/21/22 at 3:00 p.m. results (alarm initiating, tiating, and notification) did ed list with the following //pe, address, location, and d. There was only a cation and activation devices alts. The maintenance ent when the deficiency was e annual testing report was horns and strobes aren't o specific devices were noted e alarm system as required death or injury due to fire. httfication and detection arm system. Section 19.3.4.1, 9.6.1.5; on 14.6.2.4, Figure 14.6.2.4	K 34		s station es station all times. Indings of cation to 2 regarding will audit order results at	22

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02			(X3) DATE SURVEY COMPLETED	
		435036	B. WING			09/2	21/2022
	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET NATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ALE E	(X5) COMPLETION DATE
K 916	by: Based on observation interview the provider alarm in a continuous (Cummins generator include: 1. Observation on 9/2 the Cummins generate mounted in the buildinurses' station. The swas unoccupied as smoved to third floor. Interview with the matime of the observation	1.5 (NFPA 99) This not met as evidenced In, record review, and refailed to maintain a remote sty occupied location annunciator). Findings 2.1/2.2 at 10:00 a.m. revealed to annunciator was no 2 second floor patient wing taff and residents have been an confirmed those findings. The potential to affect 100% of	К	916			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		-			LIEN ICA
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION - BUILDING 03	(X3) DATE S COMPLI	
		435036	B. WING_			09/2	1/2022
	ROVIDER OR SUPPLIER			218	REET ADDRESS, CITY, STATE, ZIP CODE IS SOUTH MAPLE STREET ATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 000			K	000			
	Life Safety Code (LS occupancy) was con- Living Center was for	ey for compliance with the C) (2012 existing health care ducted on 9/21/22. Jenkin's und not in compliance with equirements for Long Term	×				
K 223	2012 LSC for existing upon correction of de K345 and K916 in cocommitment to continuately standards.	of the requirements of the ghealth care occupancies efficiencies identified at K223, onjunction with the provider's hued compliance with the fire ing Devices	K	223	The receiving/trash room has been equippe	ed with a	
SS=E	CFR(s): NFPA 101 Doors with Self-Clos Doors in an exit pass or horizontal exit, sm area enclosure are s closed position, unle device complying wi closes all such doors compartment or enti * Required manual f * Local smoke detect smoke passing thro smoke detection sys * Automatic sprinkle * Loss of power. 18.2.2.2.7, 18.2.2.2. This REQUIREMEN by: Based on observati failed to maintain tw building three (recei	ing Devices sageway, stairway enclosure, noke barrier, or hazardous self-closing and kept in the ses held open by a release th 7.2.1.8.2 that automatically s throughout the smoke re facility upon activation of: ire alarm system; and stors designed to detect ugh the opening or a required			closer and room 87 has been adjusted so the closes and latches properly. Both doors we properly fixed on 10/6/22. Facility residents were not impacted by the of this deficiency. The Director of Maintenance provided eductine maintenance staff on 10/12/22 to be succlose and latch properly. The Director of Maintenance or designee withe doors weekly x4 and monthly x3 to ensidoor closure and latching mechanism are very properly. The Director of Maintenance or will report audit results at the monthly QAP for review and recommendations.	findings cation to re doors will audit ure the vorking esignee	10/12/22
LARORATOR		R/SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE
Scott Glo					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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 06MF21

Facility ID: 0013

If continuation sheet Page 1 of 4

CENTEIN	STOR WEDIOARE &	VILDIOAID GEITVIOLO	CAN THE E CONTRIBUTION		(X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFIGATION NUMBER:	1.		CONSTRUCTION 3 - BUILDING 03	COMP	LETED
		435036	B. WING			09/	21/2022
	ROVIDER OR SUPPLIER			21	TREET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH MAPLE STREET VATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ið PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 223	Continued From page 1. Observation on 9/2 the receiving/trash row square feet and contex The corridor door was as required. 2. Observation on 9/2 the storage room num 100 square feet and of items. The door would required. Interview with the mai time of the observation The deficiency had the the occupants of that Fire Alarm System - Tourney System - Tourney A fire alarm system is accordance with an a with the requirements Electric Code, and Ni and Signaling Code. If and Signaling Code. If and Signaling Code. If acceptance, mainten available. 9.6.1.3, 9.6.1.5, NFP/ This REQUIREMENT by: Based on observation failed to test the fire a	at 1 1/22 at 11:05 a.m. revealed on was greater than 100 ined combustible items. In a closer and equipped with a closer and equipped with a closer and contained combustible dependent of the contained combustible and close and latch as intenance director at the inconfirmed that finding. The potential to affect 100% of smoke compartment. The compartment is esting and Maintenance tested and maintained in proved program complying of NFPA 70, National Fire Alarm Records of system ance and testing are readily	K		CROSS-REFERENCED TO THE APPROPRIA	Some rly. provide n and e been allings of atton to a and iii) audit f 3 orking signee	11/11/22
	for calender year 202 1. Document review of	2. Findings include: on 9/21/22 at 3:00 p.m.					

			CONSTRUCTION - BUILDING 03	(X3) DATE SURVEY COMPLETED
	435036 B	3. WNG		09/21/2022
NAME OF PROVIDER OR SUPPLIER JENKIN'S LIVING CENTER	=	21	REET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTH MAPLE STREET ATERTOWN, SD 57201	
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
revealed device test results (alam supervisory alarm initiating, and mot provide an itemized list with the information, device type, address test result as required. There was summary list of notification and a provided for test results. The mai supervisor was present when the identified. 2. Included within the annual test the comment "some horns and st working", however no specific de as required. Failure to test the fire alarm syste increases the risk of death or injutant devices of the fire alarm system. Ref. 2012 NFPA 101 Section 19. 2010 NFPA 72 Section 14.6.2.4, Section 7.12-7.14 and page 11 of Electrical Systems - Essential Electrica	notification) did ne following , location, and s only a ctivation devices Internance Int	K 345	The Cummins generator annunciator panel mounted on second floor building 2 nurses will be moved to building 2 third floor nurse on 10/12/22 where it can be monitored at a All facility residents are impacted by the finithis deficiency. The Director of Maintenance provided eduction and maintenance staff on 10/12/22 the new location of the annunciator panel. The Director of Maintenance or designee with annunciator panel for proper working of weekly x4 and monthly x3. The Director of Maintenance or designee will report audit reat monthly QAPI committee meetings for recommendations.	dings of cation to regarding will audit rder

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 3 - BUILDING 03	(X3) DATE COMP	SURVEY PLETED
		435036	B. WNG			09/	21/2022
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH MAPLE STREET VATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 916	This REQUIREMENT by: Based on observation interview the provider alarm in a continuous (Cummins generators include: 1. Observation on 9/2 the Cummins generat mounted in the buildin nurses' station. The swas unoccupied as st moved to third floor. Interview with the maitime of the observation	is not met as evidenced n, record review, and failed to maintain a remote ity occupied location annunciator). Findings 1/22 at 10:00 a.m. revealed or annunciator was ing 2 second floor patient econd floor patient wing aff and residents have been Intenance technician at the in confirmed those findings. e potential to affect 100% of	K	916			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 04			(X3) DATE SURVEY COMPLETED	
		435036	B. WING_			09/2	1/2022
	ROVIDER OR SUPPLIER			21	REET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTH MAPLE STREET ATERTOWN, SD 67201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	3	K	000			
K 226 SS=E	Life Safety Code (LS occupancy) was concliving Center was for 42 CFR 483.90 (a) recare Facilities. The building will mee 2012 LSC for existing upon correction of de K345 and K916 in commitment to continuately standards. Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if us 7.2.4 and the provisit	ey for compliance with the C) (2012 existing health care ducted on 9/21/22. Jenkin's und not in compliance with equirements for Long Term et the requirements of the ghealth care occupancies efficiencies identified at K225, enjunction with the provider's nued compliance with the fire sed, are in accordance with ons of 18.2.2.5.1 through 19.2.2.5.4.	K	226	The latch on the two hour, fire rated seperabetween building four and building two was on 10/6/22. All facility residents could be impacted by to finis deficiency. The Director of Maintenance provided edu maintenance staff on 10/6/22 to be sure the remains in place. The Director of Maintenance or designee to the latch weekly x4 and monthly x3 to ensilatch is in place. The Director of Maintenandesignee will report audit results at the more meetings for review and recommendations.	he findings cation to e latch will audit ure the noe or	
	by: Based on observatifailed to maintain the of one horizontal ex (between the buildin Findings include:	on and interview, the provider efire-resistive design of one it and building separation wall g four and building two).					
	the two-hour, fire-ra	/21/22 at 10:50 a.m. revealed ted separation wall between d building two on first floor had -rated metal door did not			*		
LABORATOR'	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Scott Glos					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 projection 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.

2022 2022

Facility ID: 0013

Scott Gloe

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	E CONSTRUCTION 04 - BUILDING 04	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	435036		STREET ADDRESS, CITY, STATE, ZIP CODE	09.	21/2022
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 226	Continued From page have a latch. The late removed. Interview at the time of maintenance supervising the did not know what latching mechanism. The deficiency could a occupants of the smo Fire Alarm System - Tock (S): NFPA 101 Fire Alarm System - Tock (S): NFPA 101 Fire Alarm System is accordance with an a with the requirements Electric Code, and NF and Signaling Code. If acceptance, maintenal available. 9.6.1.3, 9.6.1.5, NFPA This REQUIREMENT by: Based on observation failed to test the fire a (listing of devices with	hing mechanism had been of observation with the for confirmed that condition. I had happened to the affect 100% of the ke compartments. Testing and Maintenance Testing and Maintenance tested and maintained in approved program complying of NFPA 70, National FPA 72, National Fire Alarm Records of system ance and testing are readily A 70, NFPA 72 is not met as evidenced in and interview, the provider larm system as required in locations and test results)	K 228	DEFICIENCY)	22. Some roperly. and provide cation and sting have been af. e findings of education to and alarms ee will audit od of 3 me working or designee	11/11/22
	revealed device test resupervisory alarm init not provide an itemize information, device ty test result as required summary list of notific provided for test result.	on 9/21/22 at 3:00 p.m. esults (alarm initiating, iating, and notification) did ed list with the following pe, address, location, and I. There was only a eation and activation devices		21		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ETED	
		435036	B. WING		09/2	1/2022
	ROVIDER OR SUPPLIER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH MAPLE STREET VATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED 8Y FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 916 SS=F	the comment "some working", however not as required. Failure to test the fire increases the risk of The deficiency all not devices of the fire also Ref: 2012 NFPA 101 2010 NFPA 72 Section 7.12-7.14 are Electrical Systems - CFR(s): NFPA 101 Electrical Systems - Alarm Annunciator A remote annunciator A remote annunciator A remote annunciator powered is provided generating personnel hard-wired to indicate emergency powers system (e.g., building to be substituted for 6.4.1.1.17, 6.4.1.1.1 This REQUIREMEN by: Based on observation in a continuous as required to indicate the provided alarm in a continuous and required the provided alarm in a continuous as required.	e annual testing report was horns and strobes aren't o specific devices were noted alarm system as required death or injury due to fire. tification and detection arm system. Section 19.3.4.1, 9.6.1.5; on 14.6.2.4, Figure 14.6.2.4 and page 11 of 11) Essential Electric System or that is storage battery to operate outside of the alocation readily observed by a location readily observed by the alarm conditions of the ource. A centralized computer g information system) is not the alarm annunciator.	K 345	The Cummins generator annunciator pan mounted on second floor building 2 nurse will be moved to building 2 third floor nurs on 10/12/22 where it can be monitored at All facility residents could be impacted by deficiency. The Director of Maintenance provided ed nursing and maintenance staff on 10/12/2 the new location of the annunciator. The Director of Maintenance or designee the annunciator panel for proper working weekly x4 and mornthly x3. The Director Maintenance or designee will report audit the mornthly QAPI committee meetings for and recommendations.	es station es station all times. this ucation to 22 regarding will audit order of fresults at	10/12/22

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CENTERS FOR MEDICARE & MEDICAID SERVICES						T	0800-0031
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - Building 05	(X3) DATE S COMPL	ETED
		435036	B. WING_			09/2	21/2022
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	THE OFFITED				SOUTH MAPLE STREET		
JENKIN'S	LIVING CENTER			W	ATERTOWN, SD 57201		OVE
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS			345	Fire alarm test was conducted on 10/7/22.	. Some	11/11/22
	Fire Alarm System - A fire alarm system is accordance with an a with the requirement Electric Code, and N and Signaling Code. acceptance, mainten available. 9.6.1.3, 9.6.1.5, NFF This REQUIREMEN' by: Based on observation failed to test the fire (listing of devices wifer calender year 20: 1. Document review revealed device test supervisory alarm in not provide an itemiz information, device the test result as required supervisor was presidentified. 2. Included within the comment "some working", however in as required.	PA 70, NFPA 72 T is not met as evidenced on and interview, the provider alarm system as required th locations and test results) 22. Findings include: on 9/21/22 at 3:00 p.m. results (alarm initiating, itiating, and notification) did zed list with the following type, address, location, and	K	345	Fire alarm test was conducted on forming propries and alarms were not working propries alarm Co. will test alarm annually and itemized list of device type, address, locat test results as required of Fire alarm testir requirements. New strobes and alarms have ordered and will be installed upon arrival. All facility residents are impacted by the fithis deficiency. The Director of Maintenance provided edmaintenance staff on monitoring strobes and 10/7/22 The Director of Maintenance or designee fire alarm strobes and alarms for a period months to ensure strobes and alarms are properly. The Director of Maintenance or will report audit results at the monthly QA for review and recommendations.	erly. I provide ion and ig we been indings of ucation to and alarms will audit of 3 working designee	
LABORATOR	VIDECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATURE	Ξ'		TITLE		(X6) DATE
TWDOKKHI OK.	DIVERSION OF CHAINDRING				A United Landson		4014.4100

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.

Event ID: 08MF21

10/14/22

Scott Gloe

Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 04		(X3) DATE SURVEY COMPLETED		
		435036	B. WING		09/21/2022		
NAME OF PROVIDER OR SUPPLIER JENKIN'S LIVING CENTER				2	STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 916	Observation on 9/2 the Cummins generat mounted in the buildir nurses' station. The s was unoccupied as st moved to third floor. Interview with the mai time of the observation	1/22 at 10:00 a.m. revealed for annunciator was ang 2 second floor patient econd floor patient wing faff and residents have been intenance technician at the in confirmed those findings.	K	916			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BUILDING 05		(X3) DATE SURVEY COMPLETED	
435036		B. WING_	:4	09/21/2022		
NAME OF PROVIDER OR SUPPLIER JENKIN'S LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	41	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
K 345	increases the risk of continuous the deficiency all not devices of the fire ala Ref: 2012 NFPA 101 2010 NFPA 72 Section	leath or injury due to fire. ification and detection rm system. Section 19.3.4.1, 9.6.1.5; n 14.6.2.4, Figure 14.6.2.4	К3	45		
K 916 SS=F	CFR(s): NFPA 101 Electrical Systems - E Alarm Annunciator A remote annunciator powered is provided t generating room in a operating personnel. hard-wired to indicate emergency power sor system (e.g., building to be substituted for th 6.4.1.1.17, 6.4.1.1.17 This REQUIREMENT by: Based on observation interview the provider alarm in a continuous (Cummins generator include: 1. Observation on 9/2 the Cummins generat mounted in the buildin nurses' station. The s was unoccupied as si moved to third floor.	Essential Electric System Ithat is storage battery o operate outside of the location readily observed by The annunciator is alarm conditions of the urce. A centralized computer information system) is not the alarm annunciator. In the system of the system of the system It is not met as evidenced In the record review, and It is not met as evidenced In the system of the system of the system It is not met as evidenced In the system of the system of the system It is not met as evidenced It is not met as ev	K9	16		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BUILDING 05		(X3) DATE SURVEY COMPLETED	
		435036	B. WING		09/	21/2022
	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 916	Continued From page time of the observation	e 2 on confirmed those findings. ne potential to affect 100% of	K 916			

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
10703		B. WING	B. WING				
NAME OF PR	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
JENKIN'S	LIVING CENTER		IAPLE ST TOWN, SD 57201				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE		
\$ 000	Compliance/Noncomp	oliance Statement	S 000				
	44:73, Nursing Faciliti	of South Dakota, Article ies, was conducted from 22. Jenkin's Living Center					
S 000	Compliance/Noncomp	oliance Statement	S 000				
	44:74, Nurse Aide, rectraining programs, wa	compliance with the of South Dakota, Article quirements for nurse aide s conducted from 9/20/22 in's Living Center was					

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

TITLE

(X6) DATE

Scott Gloe

Administrator

10/14/22

STATE FORM

9

DO2Q11

If continuation sheet 1 of 1