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 _____	02/27/2020

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 Surveyor: 32355 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/24/20 through 2/27/20. Jenkin's Living Center was found not in compliance with the following requirements: F550, F565, F657, F658, F686, F692, F838, and F880.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550	**The DON contacted the pharmacist consultant on 3/19/20 requesting a medical record review for resident 44, specifically a review of potential interventions to manage diagnosis of Irritable Bowel Syndrome. Pharmacist recommendations were faxed to resident 44's primary care physician. DON interviewed resident 44 on 3/17/20 with conversation focusing on call light response, staffing and incidences of incontinence.** **All residents could potentially be affected by the findings for this deficiency.** **Facility staff will be re-educated by 3/27/20 regarding the importance of call light response to provide timely care to a resident and to assist the resident in maintaining dignity. Education by the DON will include that all staff can respond to call lights.** **The facility has contracted for the installation of a new nurse call system that features lights outside of resident rooms and smartphones carried by direct-care staff that will immediately alert them to call lights. Non-nursing staff will be instructed to respond to visual call lights to assure residenets that help is on the way. These features will increase staff communication and response times through immediate alerts to nursing and non-nursing personnel.**	4/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Loren W. Diekman	President/CEO	06/03/2020

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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F 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, call light audit review, and admission packet review, the provider failed to ensure dignity was maintained for one of one sampled resident (44) who had an incontinence issue. Findings include: 1. Observation and interview on 2/25/20 at 8:41 a.m. and again on 2/26/20 at 2:07 p.m. with resident 44 revealed: *She had been resting in her recliner with her feet up with the call light next to her on her bedside table. *Call lights had been answered slowly at times. *She waited anywhere from thirty minutes to an hour for staff assistance. *Due to her diagnosis of IBS she had bowel movement (BM) accidents about twice a month. *She had not usually been incontinent of urine but was concerned about the BM accidents she had. *She chose to eat evening meals in her room at times to avoid BM accidents and long waits for assistance from staff to return to her room after she ate in the dining area.	F 550	The DON, Social Worker, or a designee, will interview 5 residents per audit weekly for 4 weeks, and then monthly for 3 months, regarding call light response times. Res. 44 will periodically be included in audits. Results of the audits will be reported by the DON at monthly QAPI Committee meetings for review and recommendation.	

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F 550	Continued From page 2 -It was difficult for her to sit for long periods of time due to back problems, and she also felt more tired in the evenings. *She could get to the restroom independently using her walker. There was episodes when she could not make it in time and had BM all over that needed to be cleaned up. -When she pressed her call light for assistance, the wait after a BM accident was long. *She thought the facility was short staffed at times which caused slow call light response times. -Staff had apologized to her for the long waits. *She thought her last BM accident had been ten to twelve days ago. *BM accidents usually happened about twice a month. *That had happened mostly in the morning and sometimes in the afternoon. *She stated she hated it, and it embarrassed her. Review of resident 44's medical record revealed: *She was admitted to the facility on 8/6/15. *Her 12/24/19 Brief Interview for Mental Status (BIMS) score was fifteen indicating she had no cognitive deficit. *She had multiple diagnoses that included irritable bowel syndrome (IBS). *She had frequently been incontinent of bowel. *She walked independently in her room with the use of a walker and also used a wheelchair (w/c) when out of the room. *She required assistance of one staff person to move off the toilet and for perineal care. *Her undated, 11/16/18 revised care plan reflected the need for assistance with her activities of daily living. Interview on 2/26/20 at 2:34 p.m. with certified	F 550		

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F 550	Continued From page 3 nursing assistant (CNA) R regarding resident 44 revealed: *She was familiar with the resident, knew she had BM accidents, but had not assisted her after an accident took place. *Agreed sometimes it took the CNAs a long time to answer the call lights. *The facility completed audits on the call lights to see how long the waits really were, and the assistant director of nursing J had that information. Interview on 2/27/20 at 9:20 a.m. and at 10:08 a.m. with CNA Q regarding resident 44 revealed: *She was familiar with her and had assisted her regularly. *The staff tried to get in there as soon as possible if her light went off, because if she had a BM accident it would be all over and take time to clean up. *She was a CNA lead trainer for newly hired CNAs. -The facility expectation would be for staff to get to the residents within fifteen minutes or as soon as possible. -That was when the call light marquis would start to flash if it had not been answered. -That alerted the staff those flashing room numbers would be a priority. *As a mentor she trained the CNAs to try to get to the residents within five minutes if possible. *Weekends were a real problem for staffing. They were fully staffed maybe twice a week. Interview on 2/27/20 at 11:41 a.m. with director of nursing A regarding resident 44 revealed: *Her expectation was the staff would answer the call lights as soon as possible or prior to thirty minutes.	F 550		

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F 550	Continued From page 4 *Audit reports were completed and reviewed each morning by her and assistant director of nursing J. *If a long call light had been identified she would contact a CNA to follow-up. *She admitted there had been long call light wait times, and those usually took place in mornings or early evenings from four to six p.m. *They wanted to have call lights answered promptly for all residents. Review of the following call light audit for resident 44 from 1/14/20 through 2/22/20 revealed the following wait times: *1/14/20, 7:08 a.m. : 35 minutes (min). *1/14/20, 8:45 a.m. : 44 min. *1/18/20, 7:54 a.m. : 42 min. *1/22/20, 8:51 a.m. : 33 min. *1/27/20, 4:25 p.m. : 31 min. *1/29/20, 8:38 p.m. : 42 min. *2/3/20, 8:24 p.m. : 33 min. *2/6/20, 8:17 a.m. : 31 min. *2/7/20, 7:04 a.m. : 33 min. *2/13/20, 7:52 p.m. : 43 min. *2/18/20, 10:30 a.m. : 44 min. *2/22/20, 9:56 a.m. : 33 min. Review of the provider's admission packet that included: *"Each resident must receive-and the facility must provide-the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the residents' person-centered plan of care. *You are entitled to reasonable quality of life including: -To be treated with consideration, respect, and dignity. Recognition of your, and every resident's individuality."	F 550		

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 40771 Surveyor 42750 Based on observation, interview, record review, and policy review, the provider failed to review and revise care plans to reflect current needs of two of twenty-four sampled residents (75 and 123). Findings include:	F 657	7 There is no corrective action to be taken for resident 123's care plan due to the resident discharging from the facility on 3/7/20. The care plan for resident 75 was updated by the Registered Dietitian on 3/3/20 to reflect goals to support weight loss and weight changes. Current nutritional needs were noted in RD's progress note of 3/18/20. All residents could potentially be affected by the findings for this deficiency. The care plan team and nursing staff will be re-educated by 3/27/20 regarding the revision of care plans to reflect the current needs of the residents. The DON, RD, or a designee will audit 5 resident care plans per week for 4 weeks, and then monthly for 3 months, for accuracy of care plans. Results of the audits will be reported by the DON or RD at monthly QAPI Committee meetings for review and recommendation.	4/17/20

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F 657	Continued From page 6 1. Review of resident 123's medical record revealed: *She had been admitted on 8/20/19. *She had two pressure ulcers on admission. *She had a history of skin integrity problems. *She had a previous admission on 6/6/19 with pressure injuries and had been discharged on 7/4/19 without pressure injuries. *She had a history of inactivity and incontinence while in the facility and at home. *She also had two facility acquired pressure ulcers that had developed on 9/6/19 and 1/20/20. Review of resident 123's short term care plan with a date of 8/20/19 through 2/24/20 revealed: *Several documented skin alterations, including the two facility acquired pressure ulcers. *One notation of refusal of the pressure reducing device on her bed. *There had been no interventions regarding positioning or incontinence care. Review of resident 123's care plan 9/4/19 for skin integrity revealed: *Goal: Intact skin, but the focus was not clearly defined. *"Goal for: intact skin, free of redness, blisters or discoloration by/through review date 5/4/20." -It also indicated she was at risk for unavoidable altered skin integrity due to several factors. *No revisions for interventions after she acquired two pressure ulcers while in the facility. *The only intervention that was specific to the resident referred to the medication administration record (MAR) and treatment administration record (TAR); initiation date 2/13/20. *The care plan did not reveal she had pressure ulcers that had occurred while she was in the facility.	F 657		

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F 657	Continued From page 7 *Focus: "[name] has bladder incontinence r/t [related to] needing staff assist with her toileting tasks." -Goal was: Remain free from skin breakdown due to incontinence and brief use. -Interventions were: --"Check as required for incontinence." --"Monitor/document/report PRN [as necessary] any possible causes of incontinence." Review of 2/27/20 physician orders revealed: *Her diet did not mention added protein to assist in wound healing as mentioned on the care plan. *There had been no orders referencing scheduled treatments to prevent issues with her skin. Surveyor: 41088 2. Interview on 2/27/20 at 8:40 a.m with registered nurse (RN)/MDS coordinator T and RN/MDS coordinator U regarding residents' care plans revealed: *They did MDS assessments quarterly, and then the care plans would be implemented, and started. *When a new area of concern was identified they were contacted by ADON J or DON A to let them know changes were needed. *The nurses from the floors wrote any new information on the short term care plans regarding the residents. -Those were kept in a binder at each nurses station for the staff to refer to. *The MDS coordinators would then carry over that information to the the care plan and update it. -The unit managers did the updates from the locked units such as the memory care units. *New interventions would be added on the regular	F 657		

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F 657	Continued From page 8 care plans on a quarterly basis. *If they got a physician order they would note it on the short term care plan and if it was still relevant at the quarterly assessment then it would be added. *The nurses reported to the CNAs, and the new information is kept on a clipboard for them to review. The CNAs knew to look at it for changes. Interview on 2/27/20 at 11:11 a.m. with DON A regarding care plans revealed: *They used short term care plans on the floor. -The information on those short term care plans might or might not be added to the care plan depending if it was still relevant at the time of the quarterly MDS assessment. *She agreed their policy had been the care plans should have been updated to include relevant history or updates at least on a quarterly basis for residents. Surveyor: 32355 3. Observations, record review, and staff interviews regarding to resident 75 during the survey revealed she had frequent fluctuations with weight changes and an overall weight loss between 12/20/19 and 1/17/20. Refer to F692, finding 1. Review of resident 75's 8/21/19 comprehensive care plan revealed: *"Focus: Diabetes. *Goal: Stable weight. *Interventions: -Likes ice cream, peas, beans, white bread, spaghetti, decaf coffee, water with ice, apple juice. Preferences noted on card. Will add snack in the afternoon to help prevent hypoglycemia.	F 657		

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F 657	Continued From page 9 -Tried Magic cup on am snack cart-does not like. *Date initiated: 7/30/19 with a revision on 10/16/19." *No focus area with interventions and goals in place to support her weight loss, significant weight changes, and current nutritional needs. Interview on 2/26/20 at 10:35 a.m. with registered dietician (RD) W regarding resident 75 revealed: *She confirmed the care plan was not complete nor was it reviewed and revised to support: -Her current needs for a more enhanced diet. -Interventions and goals specific to her weight loss concerns. -A nutritional plan had been developed that was specific to her needs. *She was responsible for initiating, reviewing, and revising the dietary care plan for the residents. Interview on 2/26/20 at 2:27 p.m. with director of nursing (DON) A regarding resident 75 confirmed her care plan had not been updated and revised to reflect her dietary, nutritional, and weight loss concerns. Review of the provider's revised July 2017 Care Plan policy revealed: *"At [name] long term care plans are developed by an interdisciplinary team (IDT) with input and participation of CNA's, the resident, family and/or legal representative (when available). Prior to admission an assessment referral and initial care plan is completed. Care plans are written by exception and include measurable outcomes and identify interventions that are specific to the individual resident with defined time frames or parameters. Target dates are for 90 days unless otherwise specified. -Elements of the care plan include:	F 657		

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F 657	Continued From page 10 --Short term care plan --Active and historical diagnosis --Current physician orders --CNA flow sheet --Restorative flow sheet, if applicable --PT/OT/ST, if applicable --MAR and TAR --Diet card The care plan is reviewed and/or revised after each assessment and PRN [as needed]. The short term care plan is reviewed during this time and long term issues are carried forward to the long term care plan." *Pressure ulcer risk history section of this policy revealed: -"All residents admitted to [provider name] are considered at risk of developing pressure ulcers." -"All residents have pressure relieving or reducing mattresses on their beds as well as pressure relieving or reducing cushions on their chairs unless otherwise specified on the individualized care plans." -"All residents admitted to [provider name] are offered to be repositioned at least every two-three hours unless otherwise specified on the individualized care plan."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review,	F 658		

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F 658	Continued From page 11	F 658		

manufacturer's recommendations review, and policy review, the provider failed to ensure a high risk medication was administered according to the manufacturer's instructions for one of one randomly observed resident's (50) insulin given by one of one registered nurse (RN) (H). Findings include:

1. Observation, record review, and interview on 2/25/20 at 4:49 p.m. of resident 50's insulin administration by RN H revealed:
*The resident received Novolin 70/30 insulin 25 units scheduled and Novolin R insulin 4 units according to her sliding scale dosing.
*The Novolin 70/30 was in a vial and was a cloudy colored insulin.
*The Novolin R was in a separate vial and was clear colored.
*RN H drew up the 25 unit dose from the Novolin 70/30 vial first, and then drew up the 4 units of Novolin R into that same syringe.
*She then administered the above insulin injection into the resident's upper left abdomen.
*RN H indicated the above process was her usual practice to draw up and administer the insulin when the resident required the sliding scale insulin along with her scheduled dose.

Interview and record review on 2/26/20 at 9:08 a.m. with licensed practical nurse I regarding resident 50's insulin administration revealed:
*She had worked there for several years and usually worked on resident 50's unit.
*She had given the resident's insulin many times in the past.
*When discussing her process for the resident's insulin administration she indicated she would have:
-Put both the Novolin 70/30 and the Novolin R

There is no corrective action to be taken for resident 50 because no adverse reaction was experienced as a result of this deficiency. 4/17/20

All residents who receive insulin could potentially be affected by the findings for this deficiency.

Nursing staff were re-educated via a message over PointClickCare on 2/26/20 regarding following the manufacturer's recommendations for mixing medications - specifically insulin. Nurses H and I were re-educated verbally by the DON on 2/26/20 regarding the importance of following manufacturer's recommendations when mixing insulins. Nursing staff will be re-educated by 3/27/20 regarding the importance of following manufacturer's recommendations when mixing medications, specifically insulins.

The Quality Assurance Nurse, or a designee, will audit medication administration of 3 residents who receive insulin weekly for 4 weeks, and then monthly for 3 months, to ensure that insulin is administered per manufacturer's recommendations. The DON will present the results of the audits at monthly QAPI Committee meetings for review and recommendation.

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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 658	Continued From page 12 into the same syringe. -Drawn up the Novolin R first and then the 70/30. *She thought the clear insulin should have been drawn up first and not the cloudy. *She felt it was okay to put both those insulins into the same syringe until questioned by the surveyor. *When asked how she could verify giving the two insulins together she got a copy of the provider's Nursing 2018 Drug Handbook at the nursing station and reviewed it with the surveyor. That book revealed: -The above insulins should not have been put together into one syringe. -The instructions on page 792 for Novolin 70/30 insulin administration included: "Don't mix with other insulins." *She stated she had been mixing the two insulins for a long time, and she felt other nurses had been too. *She had been taught to put the clear insulin into the syringe first when putting more than one insulin into the same syringe. -She had not known 70/30 insulin should not have been mixed with regular. Interview on 2/26/20 at 1:56 p.m. with RN/staff development director C regarding the above concern revealed: *She confirmed the nurses should not have put both insulins into the same syringe if the manufacturer's instructions had indicated not to. -That would have been considered a medication error. *She had not been aware the nurses had been putting resident 50's Novolin 70/30 and R insulins into the same syringe when she needed sliding scale insulin along with her scheduled dose. *She indicated there was no policy for insulin	F 658		

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F 658	Continued From page 13 administration. -The expectation would have been to follow the manufacturer's instructions for use. Interview on 2/26/20 at 2:23 p.m. with assistant director of nursing J regarding the above concern revealed: *She had been taught to draw up the clear insulin before the cloudy when putting insulins into the same syringe. -That would have been the Novolin R first and then the Novolin 70/30. *She had not been aware the Drug Handbook indicated not to mix 70/30 insulin with any other kind of insulin. *She had called their consultant pharmacist to clarify the insulin mixing after she had been asked by the nurse this morning. -The pharmacist confirmed the nurses should not have been putting the above insulins into the same syringe. Review of the provider's revised September 2018 Medication Administration policy revealed: *"An accurate and safe method of administering medications will be carried out." *"4. If unfamiliar with the med, check in the drug handbook, call the Pharmacist and/or physician for clarification or look for manufacturer guidelines if it is a recently released med." *"7. Check for any special instructions the medication has for administration..."	F 658		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686	The facility's policy and procedure for pressure ulcers was updated to address steps to take if a pressure ulcer worsened, and also how to determine the effectiveness of interventions and/or treatments. Facility's Pressure Ulcer policy was updated to include the use of the Braden Scale to provide staff with information regarding	4/17/20

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F 686	Continued From page 14 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to appropriately implement, monitor, and alter care for three of six sampled residents (21, 118, and 123) who had multiple co-morbidities and were at risk for pressure ulcer/pressure injury development. Findings include: 1. Review of the provider's July 2017 Care Plan, Resident-Centered Facility Standards revealed: *"Care plans are written by exception and includes measurable outcomes and identify interventions that are specific to the individual resident with defined time frames or parameters." *Pressure ulcer risk history section of policy revealed: -"All residents admitted to [provider name] are considered at risk of developing pressure ulcers." -"All residents have pressure relieving or reducing mattresses on their beds as well as pressure relieving or reducing cushions on their chairs unless otherwise specified on the individualized care plans." -"All residents admitted to [provider name] are offered to be repositioned at least every two-three	F 686	residents who may be at high risk. Resident 21's care plan was updated with interventions for the CNA's to follow to reduce pressure on the resident's wound. A nursing order to elevate lower extremities while in a recliner was added to the treatment plan for resident 118. The care plan for resident 118 was updated with interventions for CNA's to follow to take pressure off the wound. There is no corrective action to be taken for resident 123 because this resident was discharged on 3/7/20. Res. 123's pressure ulcer was healed on 2/24/20. All residents could potentially be affected by the findings for this deficiency. Nursing staff will be re-educated by 3/27/20 regarding the importance of documenting resident refusals of care and or/treatment on the Treatment Administration Record and, as indicated per clinical judgement, in a progress note. Nursing staff will also be re-educated by 3/27/20 regarding the following: (1) importance of offering alternatives to a resident who refuses a treatment plan; (2) importance of offloading to prevent pressure; (3) attempts to identify other factors, such as pain, if a resident refuses to reposition. DON verbally re-educated Wound Care Nurse on 3/16/20 regarding the importance of documenting the depth of a wound. The Wound Care Nurse, or a designee, will conduct audits of residents with pressure ulcers weekly for 4 weeks, and then monthly for 3 months to review steps taken in the event a pressure ulcer worsens, completion of a Braden Scale, and that the care plan addresses interventions for CNA's to follow to reduce pressure	

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F 686	Continued From page 15 hours unless otherwise specified on the individualized care plan." Review of the provider's June 2018 policy for Pressure Sores Prediction and Prevention revealed: "*Policy: It is the responsibility of the Nursing staff at [provider name] to identify residents at risk, initiate preventive measures, and exercise early identification and treatment when noted." *"The four most critical factors that place our residents at risk are: -Pressure over a bony prominence. -Shearing-occurs when layers of tissue slide over each other. -Friction-occurs when two surfaces move against each other (as when a resident is slid in bed). -Moisture-leads to breakdown of the skin which enhances the risk of ulceration. This can be from urine, feces, perspiration or exudates [drainage]. *To identify specific residents at risk, an initial assessment will be done with each admission referral and interventions put in place as indicated." Review of the provider's June 2018 Pressure Ulcer policy revealed: *No documentation of steps to take if pressure ulcer worsened. *It did not address determining if current interventions or treatments were effective. 2. Review of resident 118's medical record revealed: *She had been admitted on 8/15/16. *She had diagnoses that included: Type II diabetes with diabetic polyneuropathy; peripheral vascular disease; venous insufficiency; congestive heart failure; chronic kidney disease,	F 686	to a wound. The Wound Care Nurse will report on the results of audits at monthly QAPI Committee meetings for review and recommendation.	

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F 686	Continued From page 16 stage 3; and edema. *On 2/24/20, her Brief Interview for Mental Status (BIMS) score was fifteen, indicating no cognitive deficit. *She was non-ambulatory and used a wheelchair to move around the facility. *She required extensive assistance of two staff to transfer and extensive assistance of one staff person for movement on and off of the unit, for dressing, toilet use, and personal hygiene. *She had a fall on 5/24/19 that resulted in a femur fracture that prompted the need for an immobilizer on her right leg. Further review of resident 118's medical record revealed: *A 6/3/19 pain assessment had been completed. -Resident reported frequent pain in the past five days which made it hard for her to sleep at night. She had rated her pain a ten on a scale of zero to ten with ten being the worst. *A 6/4/19 nursing assessment noted no alteration in skin integrity. -Skin on heel had been discolored, "very dry", and Sween cream had been applied. *On 6/5/19 staff discovered an unstageable pressure ulcer on her right lower calf that had been under an immobilizer device to stabilize her leg. Observation and interview on 2/25/20 at 8:01 a.m. with resident 118 revealed: *She had been resting in her recliner with her feet down. *She did not have a bed in her room and preferred to sleep in her recliner. *She had not been wearing a heel protector but did have ace wraps on both of her lower legs as ordered.	F 686		

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F 686	Continued From page 17 -The heel protector was sitting on top of her dresser. *There had not been pillows or protection under her heel or to the back of her right leg to keep pressure off of the area. *She stated she did not like to wear the heel protector and preferred to wear gripper socks. Observation and interview on 2/25/20 at 9:59 a.m. and 2/26/20 at 1:55 p.m. with resident 118's daughter revealed: *The resident was resting in her w/c with gripper socks on. *She had no pillows or protection under her left heel or the back of her right leg. *Her mother had not liked to wear the heel protector on her right foot and refused to wear it. Review of weekly wound observation assessment completed on 6/5/19 for resident 118 revealed: *The wound was an unstaged, acquired pressure ulcer that measured 55 millimeters (mm) long x 70 mm wide. Infection had been suspected with redness noted and an odor. -Treatment included: Curad sterile dressing with a Biatin non-adhesive 4x4 over the area. Sheep skin boot over the area. Immobilizer was replaced. -Special equipment/preventative measures included: "Reduce air loss pad to bed, padding placed at the site of the wound." *Fax sent to physician on 6/7/19: "resident has blood blister size of golf ball that is oozing out on inner side. [Facility name] wound nurse assessed and think maybe she should see wound care." Review of resident 118's physician's orders on the June 2019 treatment administration record (TAR) included:	F 686		

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F 686	Continued From page 18 *"Skin Assessment (Medicare 14-day). Do a head-to-toe assessment and document if res [resident] has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, every shift until 6/12/19." Start date 5/31/19. -Nursing staff had not documented/initialed those orders had been followed on the TAR. *"Monitor CMS [circulation, motion and sensitivity] Rt L/E [right lower extremity] every shift for Rt L/E fx [fracture] while using brace." Start date 6/3/19. -Nursing staff had initialed these orders had been followed on the TAR. *"Monitor for pain r/t [related to] Rt L/E fx every shift for Rt L/e fx until healed." Start date 6/3/19. -Nursing staff had initialed those orders had been followed on the TAR. *"Monitor skin condition Rt L/E fx every shift for Rt L/E fx while brace is in use." Start date 6/3/19. -Nursing staff had initialed these orders had been followed on the TAR. *Wear bilateral heel lift boots at all times. Every shift for prevention. Start date 6/14/19. -Nursing staff had initialed those orders had been followed on the TAR. -No refusals had been documented on the TAR. Review of a weekly wound observation assessment on 6/19/19 for resident 118 revealed: *The wound was an unstaged, acquired pressure ulcer. It measured 55 mm long x 70 mm wide, and no depth was recorded. -Preventative measures included: heel lift boots. Review of nursing notes on 7/22/19 revealed a second pressure ulcer had been discovered by nursing staff on resident 118's right heel and revealed: *A 7/22/19 weekly wound assessment had	F 686		

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F 686	Continued From page 19 identified the area as an acquired, stage II pressure ulcer by the wound clinic nurse. *The wound measured 20 mm long x 25 mm wide and was 1 mm deep. -Preventative measures: heel lift boots and cushion in chairs. --That had not been a change from prior interventions. *A 8/7/19 weekly wound assessment was completed after wound clinic physician visit had identified the area as an acquired, stage IV pressure ulcer. -The wound measured 40 mm in long x 54 mm wide with no depth noted. -Special equipment/preventative measure: heel lift boots and cushion in chair. *The short term care plan had not included interventions for CNAs to follow to take pressure off the wound when it had been discovered on 6/5/19. Review of the 9/17/19 wound clinic physician's notes regarding resident 118 revealed: *A severe ulcer of right leg near the ankle. *Discussed amputation options with resident and her daughter regarding pressure ulcer. -The resident was not willing to consider amputation. Review of resident 118's care plan revealed: "Goal initiated 1/9/19 and revised on 8/28/19: [Name] pressure ulcers will heal and her skin will be clean and intact skin by the review date. *Interventions: -[Name] has developed pressure ulcers to her right calf and heel. [Name] was going to the wound clinic for treatment but is now being treated in house per wound specialist	F 686		

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F 686	Continued From page 20 recommendations/doctor's orders. Staff will monitor and document wound per [facility initials] protocol. Initiated 6/7/19 and revised on 1/28/20. -[Name] has refused to wear slippers during the day and has been educated on the impact that could cause to her right foot. She has chosen to continue to wear her gripper socks/shoes throughout the day. Initiated 1/9/19 and revised on 1/28/20. -Follow orders for treatment of injury. Initiated 1/9/19 and revised on 1/28/20. -Keep skin clean and dry. Use lotion on dry skin. Initiated 1/9/19 and revised 1/9/19. -Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, s/sx [sign/symptom] of infection, maceration, etc. to MD. Initiated 1/9/19. -Staff will reposition [Name] per care plan standard or as [name] allows (she does at times refuse). [Name] has a pressure reducing w/c [wheelchair] cushion; to help heal and prevent additional skin breakdown. [Name] has been refused a bed in her room; [Name] has been educated on the potential benefits of sleeping in a bed and she prefers to sleep in her recliner, she does have a hx [history] of refusing to transfer into her recliner for sleep. Initiated 6/7/19 and revised on 1/28/20." *The resident had refused to wear a boot protector, but nothing new had been trialed to replace it. Interview on 2/26/20 at 9:20 a.m. with CNA Q regarding resident 118's care revealed: *She did not have a bed in her room and preferred to sleep in her recliner. *They tried to have her keep her feet elevated when in the recliner. *They floated her heels with three pillows.	F 686		

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F 686	Continued From page 21 *When she is in her w/c they cued her to keep her feet well placed. -She had a habit of resting the back of her heel against the foot pedal of the w/c that was where her injury was located. They tried to watch for that and reposition her. *She had refused to wear the heel boot protector and wore slipper socks. *They tried to reposition her every two hours. -She had refused assistance at times and they documented the refusals. Interview on 2/26/20 at 11:08 a.m. with assistant director of nursing J and registered nurse (RN)/staff development C regarding resident 118 revealed: *They had assessed the wound on 6/5/19, and the resident had seen a physician at the wound care clinic on 6/14/19. *The resident had developed a second pressure ulcer to her heel. *They had tried a wound vacuum, but the resident had not tolerated it well. *Stated her physician had later discussed amputation with the resident, but she had refused. *She continued to be seen at the wound clinic every month or more often if needed. *They continued to do dressing changes with cast padding and Ace wraps to protect the area. *Agreed it had been a real problem, but the wounds had made some improvements. Interview on 2/26/20 at 1:54 p.m. with licensed practical nurse (LPN) CC regarding resident 118 revealed: *She was familiar with the resident's needs and history.	F 686		

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F 686	Continued From page 22 *Confirmed the expectation had been for staff to remove the resident's immobilizer to complete a skin assessment then initial on the TAR. *Stated she had removed the immobilizer to complete skin assessments. *She remembered when the pressure ulcer had been discovered, and she had issues with pain. *The wound had been a blister that had "popped," but the skin was still covering it -She thought the pain was related to the fracture and did not think there had been a skin injury that had caused pain. *The resident did not specify the location of pain under the immobilizer. *She was unsure why the pressure injury had gotten so bad if assessments were being done as ordered. *She currently had Ace wraps on both legs for issues with edema and also to protect the areas. 3. Review of resident 21's medical record revealed: *She had been admitted on 5/5/14. *She had diagnoses that included: weakness, spondylolisthesis of lumbar region, intervertebral disc displacement of lumbar region, spinal stenosis of lumbar region, history of unrinary tract infection (UTI), congestive heart failure, and asthma. *She had developed a pressure injury to her left posterior upper thigh area that had been discovered on 7/14/19. *On 12/10/19 annual MDS assessment revealed: -A BIMS score of fifteen indicating no cognitive deficit. -She was non-ambulatory and used a wheelchair to move about the facility. -She required extensive assistance of one staff person with bed mobility to reposition, transfer,	F 686		

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F 686	Continued From page 23 dress, and for toilet use. -She depended on staff to develop and implement interventions to prevent her from pressure injuries. Observation and interview on 2/25/20 at 9:49 a.m. and on 2/25/20 at 10:39 a.m. with resident 21 revealed: *She was resting in a recliner with her legs up. There was no pressure relieving cushion on the seat of her recliner. *She had an air mattress and used a cushion in her w/c. If she used her electric scooter she moved the cushion to her scooter seat. *She was not able to reposition herself to relieve pressure on her bottom. *At night she used her call light to alert staff that she needed to be repositioned. -Staff came about every three hours, and she preferred they not wake her up to reposition her. *She stayed in her w/c after she got up in the morning and rested in her recliner with her legs up after lunch. Review of resident 21's care plan revealed: "Goal initiated 5/1/18 and revised on 12/26/19: [Name] will have intact skin, free of redness, blisters or discoloration by/through review date. *Interventions: -APP [alternating pressure pad] is being used on [Name] bed to help prevent skin alterations. [Name] does prefer to sleep/rest in her recliner. Initiated 5/1/18 and revised 10/24/19. -Follow MAR/TAR [medication administration record/treatment administration record] for any current treatments and monitor for healing. Initiated 5/1/18 and revised on 5/1/18. -Pressure reducing cushion is used to help prevent skin alterations. Initiated 5/1/18 and	F 686		

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F 686	Continued From page 24 revised 10/24/19. -Staff will repo [reposition] [Name] per the Care Plan Standard or as [Name] allows. Initiated 5/1/18 and revised 1/28/20." Further review of the short term care plan revealed it had not specifed interventions for the CNAs to follow to reduce pressure off the wound after it had been discovered on 7/22/19. Interview on 2/26/20 at 8:39 a.m. with ADON J regarding the use of Braden assessment scale for identifying residents who were at risk of developing pressure ulcers revealed: *They did not use the Braden scale assessment or any type of assessment tool. -They had considered all residents as high risk and put preventative interventions on all the care plans. *All residents had a cushion in their chair, and a pressure reducing mattress to prevent pressure injuries. Interview on 2/26/20 at 11:02 a.m. with ADON J and RN/staff development C regarding resident 21 revealed: *They were responsible for wound care for all of the residents of the facility. *The resident had the wound since 7/15/19. *It had been difficult to get the resident off the area since she participated in several activities while seated in her w/c. And she often sat in her recliner. *A cushion had been used for her w/c and scooter, and she had an air mattress on her bed. *They had educated her on the need to reposition and offload that area. *They had tried Z-guard barrier cream, a wound gel with collagen powder, collagen powder alone,	F 686		

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F 686	Continued From page 25 and had considered electrical stimulation to the area to promote healing. *A wound specialist had seen the resident for the past three or four months. *The wound was healing. Interview on 2/27/20 at 9:21 a.m. with CNA Q regarding resident 21 revealed: *She had worked with her and was familiar with her care. *The CNAs used the short term care plan and the report from the nursing staff to be informed of changes. -They also used a clip board with information about the resident's care that was at the nurses station. -That was how they knew what to do for care of the residents. *The resident could not reposition on her own. -She was repositioned every two to three hours. -If she had been with visitors she would not allow it. Review of resident 21's 7/22/19 weekly wound assessment revealed: *A stage II acquired pressure ulcer on her right posterior thigh. *It measured 40 mm long x 35 mm wide with no depth documented. Review of resident 21's 2/25/20 weekly wound assessment revealed: *A stage III acquired, pressure ulcer in the same location, and they noted it was worsening. *It measured 20 mm long x 9 mm wide with no depth documented. 4. Interview on 2/27/20 at 11:11 a.m. with DON A regarding residents 118 and 21 revealed:	F 686		

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F 686	Continued From page 26 *They continued to look at pressure ulcers at the facility. *All residents had a cushion in their chair, and a pressure reducing mattress to prevent pressure injuries from occurring. -Those interventions had not prevented skin breakdown. -She believed that resident 118's injury was not preventable due to her diabetes and vascular issues. -She thought the achilles wound on resident 118 was a deep tissue injury that continued down to the heel area. --She believed the nursing staff had followed orders, done skin assessments, and removed the immobilizer. -Stated the resident had refused to sleep in a bed which complicated things, and they would continue to encourage her to do so. -They had interventions in place such as putting pillows under her legs while she was in her recliner. *The facility documentation stated it was an acquired pressure ulcer, and the use of pillows was not mentioned on the short term care plan or comprehensive care plan. *Regarding resident 21: -She spent a lot of time with her husband and out of her room. -The resident was often seated in her w/c or recliner and it was difficult for staff to offload the area. -The CNAs repositioned her whenever possible. -They had interventions of a cushion in her chair and an air mattress on her bed. Surveyor: 40771 Surveyor 42750	F 686		

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F 686	Continued From page 27 5. Review of resident 123's medical record revealed: *She had been admitted on 8/20/19 with two pressure ulcers. *Her diagnoses included: pain, diabetes mellitus, urinary incontinence, and Rheumatoid arthritis. *On 11/12/19, her BIMS assessment score was thirteen, indicating no significant cognitive deficit. *Minimum Data Set (MDS) quarterly assessments on 11/12/19 and 2/4/20 revealed she did not reject care and ambulated with one staff person. *On 9/6/19, she had developed a stage two pressure ulcer on her left posterior thigh. *On 1/20/20, she had developed a stage two pressure ulcer on her left buttock. -It was later indicated as a stage three pressure ulcer. Random observations between 2/26/20 and 2/27/20 of resident 123 revealed she was sitting in her recliner with pressure reducing cushion on her chair. Interview on 2/26/20 at 1:45 p.m. with resident 123 revealed she would refuse to move if she was in pain. Interview on 2/26/20 at 5:39 p.m. with ADON J revealed: *All residents were considered high risk for pressure ulcers. *They did not use Braden scale (assessment) to determine the risk of developing a pressure ulcer for an individual. *All residents got pressure relieving devices. *There was no tool used to determine if one resident was at a higher risk than another.	F 686		

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F 686	Continued From page 28 Interview on 2/27/20 at 10:13 a.m. with the DON A and RN/staff development director/wound care nurse C revealed: *Resident 123's pressure ulcer had been caused by sitting in one place for too long, at one time, and moisture. *A moisture barrier cream was started after the pressure ulcer was identified on 9/16/19. -They considered this intervention effective because between September and January she did not get any pressure ulcers. -There were no changes with her interventions after she acquired another pressure ulcer in January 2020. -Review of resident 123's 11/19/19 care plan revealed no interventions for repositioning or how to respond to refusals. *Resident had often refused to reposition herself or allow staff members to assist her to the toilet, or to reposition. *They had accepted her refusal but had not attempted to identify precipitating factors such as pain. *They did not use the Braden scale or any other skin assessment scale for documenting pressure ulcer risk. Interview on 2/27/20 at 12:03 p.m. with the medical director revealed he: *Had been the medical director for the previous year. *Attended monthly quality assurance process improvement meetings. *Agreed if interventions were not working other approaches should have been tried with residents. *Was not aware of benchmarks for pressure ulcers, they were reviewed on a case by case basis versus systemic review.	F 686		

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F 686	Continued From page 29 *The meetings were used as a reporting tool for the different disciplines. *They talked about interventions and new ideas, but usually there had been nothing more that could be done. *Agreed that it would be an expectation for staff to remove an immobilizer to do skin assessments. *Agreed if a resident had been in pain, treat the pain, and then staff should come back and look for what could have caused the pain. *Confirmed resident 21 sat a lot, and it was difficult for staff to assist her to offload. *Agreed if there were refusals they should have tried other things and to include all disciplines. *Agreed the facility needed to improve documentation because they documented some data in a paper chart and some electronically.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692	**The care plan and nutritional assessment for resident 75 ws updated by the Registered Dietitian on 3/3/20. Resident 75's physician was updated on 2/27/20 regarding her weight loss. Resident 75 was counseled by the RD on 3/20/20 regarding weight loss/nutritional concerns. A nursing order to monitor mood and dietary intake was entered into resident 75's medical record for a date range of 2/26/20 to 3/11/20.** **All residents with poor dietary intake could potentially be affected by the findings for this deficiency.** **Nursing staff will be re-educated by 3/27/20 regarding the procedure for alerting the RD to noted weight changes, and also the importance of monitoring a resident with medication changes related to weight loss. The RD will provide education to the nursing and dietary staff by 3/27/20 regarding the importance of updating physicians of resident weight loss.** **The RD, or a designee, will audit 5 resident charts each week for 4 weeks, and then monthly for 3 months to review risk of weight loss, updated care plan and nutritional assessment, physician notification, and resident education. The RD will report results of the audits at monthly QAPI Committee meetings for review and recommendation.**	**4/17/20**

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F 692	Continued From page 30 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure: *The nutritional status was monitored for one of three sampled residents (75) who had a significant weight loss and was nutritionally at risk. *Nutritional intakes had been monitored for one of three sampled residents (75) who had a medication change to help increase her appetite. Findings include: 1. Observation and interview on 2/24/20 at 5:06 p.m. with resident 75 revealed she had: *Been laying in her bed resting. *Appeared very thin and frail with her bones easily visualized through her skin. *Required the use of oxygen and became short-of-breath when talking to the surveyor. *Been alert and able to voice her concerns without difficulty. *Spent the majority of her days in her room. *Stated: -"Why would I want to go out there?" -"Who are you and just what do you want anyway?" -"You must be in on it." -"And meals? No, I eat in my room." Review of resident 75's medical record revealed: *An admission date of 7/16/19. *Her diagnoses included: diabetes, dissociative and conversion disorder, major depression,	F 692		

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F 692	Continued From page 31 vascular dementia, delusional disorders, and chronic obstructive pulmonary disease. *She required staff support of one person for all activities of daily living (ADL). -That had included bed mobility, transfers, walking, dressing, and personal hygiene. *She: -Frequently refused assistance from the staff with those ADLs. -Was able to eat independently after the staff had set it up for her. -Was dependent on the staff to develop and implement a plan of care for her. -Was seen by telehealth and another counseling institute to monitor the stability of her mental health. -Chose to spend a majority of her time in her room. *Her level of confusion fluctuated from day-to-day. *She had: -A history of making unsafe choices for herself that had impacted her weight and nutritional health. -Frequently refused to have her weight monitored to ensure any concerns had been appropriately monitored and treated in a timely manner. -History of non-compliance with taking her medication. Review of resident 75's weight record revealed on the following: *11/20/19: 116 pounds (lb). *12/20/19: 116.5 lb. *1/17/20: 106 lb. indicating a 3 percent (%) weight loss since 12/20/19. *1/24/20: 104.5 lb. indicating a 5% weight loss since 12/20/19. *2/14/20: 104 lb. indicating a 7.5% weight loss	F 692		

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F 692	Continued From page 32 since 11/20/19. Review of resident 75's progress notes revealed: *There were none from the registered dietician (RD) during those above weight record times. -The last nutrition/dietary note by the RD had been on 10/16/19. *On 1/22/20 the dietary manager (DM) had completed a quarterly review for the assessment reference date of 1/14/20. *There was no further nutrition/dietary documentation from the RD or DM after 1/22/20. Review of resident 75's 8/21/19 comprehensive care plan revealed: *"Focus: Diabetes. *Goal: Stable weight. *Interventions: -Likes ice cream, peas, beans, white bread, spaghetti, decaf coffee, water with ice, apple juice. Preferences noted on card. Will add snack in the afternoon to help prevent hypoglycemia. -Tried Magic cup on am snack cart-does not like. *Date initiated: 7/30/19 with a revision on 10/16/19." *No focus area with interventions and goals in place to support her weight loss, significant weight changes, and current nutritional needs. Review of resident 75's physicians' orders revealed on: *1/24/20: she had been seen by her primary physician for a sixty day update. -There was no documentation to support she had been assessed by the physician for a 5% weight loss. *2/19/20: The telehealth physician had increased her Remeron for her depression and appetite concerns.	F 692		

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F 692	Continued From page 33 -There was no documentation to support what appetite concerns had been reviewed for her. Review of resident 75's 11/19/19 through 2/25/20 nursing progress notes revealed no documentation to support: *Her weights had been monitored and reported to the RD, DM, and physician. *She refused to be weighed more than once a month. *She had an appointment on 2/19/20 with telehealth, and her medication was changed. *The dietary department was notified of those medication changes to help with her appetite. *Her meal intakes had been monitored after the change in her medication to support: -Acceptance and toleration of the increased dosage. -Whether her appetite had improved or not. Interview on 2/26/20 at 10:35 a.m. with RD W, CNA X, and LPN Z regarding resident 75 revealed: *She had: -A history of fluid retention due to (d/t) her non-compliance with taking her diuretic medication. -A tendency to isolate herself in her room and preferred to eat her meals there. That had made it difficult to monitor her nutritional intakes. -Very specific likes and dislikes for certain foods, and they tried to accommodate those preferences as much as possible. *She was scheduled for a weekly bath and weight every Wednesday. -Frequently she had refused those baths and weights. *The staff were to have informed the charge nurse with any weight discrepancies of 3 lbs.	F 692		

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F 692	Continued From page 34 -A re-weight should have been completed that same day. -She had frequently refused those attempts to re-weigh her. *RD W and LPN Z had not been aware of her: -Significant weight loss from 12/20/19 through out 1/17/20. -Appointment with telehealth on 2/19/20 and the medication changes from that appointment to help with her appetite. *They agreed: -She was considered nutritionally at risk for weight loss and should have been monitored closer. -Her nutritional intakes, weights, and toleration of that dosage change should have been monitored and assessed by both the nursing and dietary departments. *The RD and DM tried to review the resident's weights weekly and communicate with nursing when a change or concern was identified. -They agreed that had not occurred for her and should have. *The RD confirmed the care plan was not complete nor was it reviewed and revised to support: -Her current needs for a more enhanced diet. -Interventions and goals specific to her weight loss concerns. -A nutritional plan had been developed that was specific to her needs. *The RD was responsible for initiating, reviewing, and revising the dietary care plan for the residents. Interview on 2/26/20 at 2:27 p.m. with director of nursing (DON) A regarding resident 75 revealed: *She confirmed the above medical record review on the resident.	F 692		

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F 692	Continued From page 35 *She agreed: -Documentation by both the nursing and dietary departments had not supported appropriate monitoring and assessing of a resident who was at risk for a weight loss. -Intakes should have been completed and monitored on a resident who had a medication change to help increase their appetite. Review of the provider's undated and unsigned Significant Weight Changes policy revealed: *"Resident with significant weight changes are reported to the care team on a regular basis." *"Interventions may include: -Assessing risk factors that may affect the change. -Reweighing the resident for accuracy. -Identifying what nutrition plan may be effective for that person. -Documenting findings in the medical record. -Doing a detailed food intake. -Reviewing the care plan. -Adjusting the nutritional plan. -Notifying the physician and family. -Adjusting the times/week a resident is weighed."	F 692		
F 838 SS=D	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a	F 838	The Facility Assessment form will be updated to reflect the layout of the facility and all pertinent information int he Assessment will be reviewed for accuracy. The findings implied that the Facility Assessment should be the key document used for determining staffing levels on various units or floors of the facility. We do not see that as a specific requirement under federal regulations. Guidance to Surveyors for F 838 states that, "...the facility assessment must include an evaluation of the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs." Our Facility Assessment lists the overall number of facility staff as required in the regulations. The facility reviews the acuity of our residents on a daily basis and determines staffing levels on each unit accordingly. In addition, the facility's administrative team meets as needed to discuss staffing levels and distribution of staff.	4/17/20

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F 838	Continued From page 36 substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide	F 838	F 838 All residents in the facility could potentially be affected by the findings for this deficiency. Administrative staff will review and update the Facility Assessment to ensure that it accurately reflects the resources necessary to care for the residents competently both during day to day operations and also emergencies. Staff will also be re-educated by 3/27/20 regarding the use of the Facilty Assessment in facility planning. The Quality Improvement Director, and members of the Administrative team, will review the Facility Assessment document on a quarterly basis for one year, and then annually thereafter. Results of the quarterly reviews will be reported by the Quality Improvement Director at montly QAPI Committee meetings for review and recommendation.	

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(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 838	Continued From page 37 services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on record review and interview, the provider failed to ensure the facility assessment had addressed the staffing resources needed to ensure appropriate care and services were available to the residents. Findings include: 1. Review of the provider's 8/20/19 facility assessment revealed: *Their resources for staffing needs had not been addressed. *The assessment was eighteen pages long, and it included: -An overview indicating it was a 162-bed skilled nursing facility licensed by the State of South Dakota and certified by both the Medicare and Medicaid programs. -Services offered were: skilled nursing care and professional physical, occupational, and speech therapy services for both inpatient and outpatients. -The resident capacity was 162 with the current number of residents at 148. --The overall acuity of residents was left blank. -A listing of the total number of employee positions for administration and staff. --It had not specified how many staff were	F 838		

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	435036	A. BUILDING _____ B. WING _____	02/27/2020

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

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F 838	Continued From page 38 needed to care for the residents or how they would have been scheduled/assigned. -A listing of totals for resident diagnoses. --It had not specified how those diagnoses would have impacted their care needs such as how much assistance the residents would have potentially required from the staff. -Eight of the sixteen pages listed physical environment and equipment within the building. -A listing of services provided by contract with a plan for annual reviews of them. -A listing of competency-based training for staff. -A page of health information managing and sharing. -A page for facility-based and community based risk assessment annual reviews. *There had been no mention of: -The facilities multi-level, multi-unit layout that included seven distinct nursing units. --Three of those seven were memory care units. -The third floor having more residents overall with higher level of care needs. -The usual amount of assistance required by the residents based on their medical and mental health diagnoses. -How the facility would have been staffed to ensure the residents' care needs were being met. Interview and facility assessment review on 2/27/20 at 7:57 a.m. with director of nursing A and administrator B revealed: *They confirmed the assessment had not included and addressed their staffing needs. *It listed all the staff they had, but it had not identified what staffing was needed to ensure appropriate care and services were available to the residents. *They confirmed the facility was unique with having had three specific memory care units and	F 838		

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F 838	Continued From page 39 four other nursing units within the three levels of the building. *They agreed the third floor of the building had more residents and the increased level of care needs. *The first floor memory care unit held residents with less care needs who were ambulatory. Interview and facility assessment review on 2/27/20 at 10:00 a.m. with quality assurance and therapy director K revealed: *She assisted with the development of the facility assessment and the overall template for it. *She confirmed the staffing needs were not addressed on their assessment. *There was no specific policy on the process for the facility assessment. -They would have followed the regulation.	F 838		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880	4/17/20 No corrective action was necessary for residents 132 and 142 because neither was adversely affected by the findings for the deficiency. All residents could potentially be affected by the findings for this deficiency. The DON provided one to one education for CNA AA on 3/19/20 regarding proper hand hygiene and infection control. Nursing staff will be re-educated by 3/27/20 regarding the importance of maintaining sanitary conditions during resident cares.	

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F 880	Continued From page 40 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	) The Infection Control Nurse, or a designee, will audit the personal care of 5 residents per week for 4 weeks, and then monthly for 3 months, to observe hand hygiene during resident cares. The results of the audits will be reported by the Infection Control Nurse at monthly QAPI Committee meetings for review and recommendation.	

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F 880	Continued From page 41 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained during personal care for 2 of 11 sampled residents (132 and 142) by one of one certified nursing assistant (CNA) (AA). Findings include: 1. Observation on 2/25/20 at 8:31 a.m. of CNA AA with resident 132 revealed: *The resident had been in the bathroom waiting for assistance. *He had required the use of a mechanical stand-aide for transfers and was already hooked-up to it. *The CNA sanitized her hands and put on a clean pair of gloves prior to assisting the resident with personal care and a transfer. *With those gloves on she: -Took a garbage bag off of a roll that had been on top of the glove box container. -Opened a dresser drawer and took out an incontinent brief and a bottle of perineal wash. -Touched the water faucet handle without using a barrier and turned on the water to wet a washcloth. -Assisted him with the mechanical stand-aide and raised it up to transfer him off of the toilet and provide personal care.	F 880		

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F 880	Continued From page 42 *With those now soiled gloves still on she took the washcloth, sprayed it with perineal cleanser, and provided perineal care for him. -She removed her gloves, put a clean incontinent brief on the resident, pulled up his pants, and transferred him to a recliner. *Then washed her hands and left the room. 2. Observation on 2/25/20 at 1:03 p.m. of CNA AA with resident 142 revealed: *The resident had been: -In her room sitting in a recliner. -Waiting for the CNA to assist her with a transfer, toileting, and personal care. *She had required the use of a gait belt and a one person assistance for stand-pivot for transfers. *The CNA sanitized her hands and put on a clean pair of gloves prior to assisting the resident with a transfer and personal care. *With those gloves on she: -Put a gait belt around the resident's waist and transferred her to a wheelchair (w/c). -Opened the bathroom door and pushed the resident into the bathroom. -Assisted the resident to stand-up, pull down her pants, remove her soiled incontinent brief, and assisted her to sit down on the toilet. -Took a garbage bag off of a roll that had been on top of the glove box container and opened it. -Opened a cupboard door in the bathroom and took out a clean incontinent brief. -Touched the water faucet handle without using a barrier and turned on the water to wet a washcloth. -Assisted the resident to stand-up. *With those now soiled gloves still on she took the washcloth, sprayed it with perineal cleanser, and provided perineal care for her. -She removed her gloves, put a clean incontinent	F 880		

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F 880	Continued From page 43 brief on the resident, pulled up her pants, and transferred her into the w/c. *Then washed her hands and left the room. 3. Interview on 2/25/20 at 1:21 p.m. with CNA AA regarding the above observations of personal care for residents 132 and 142 revealed: *That had been her usual process for providing personal care for the residents. *She stated: "I put gloves on too soon." *She had not recognized the process as unsanitary until after the observations were reviewed with her. *She agreed: -The personal care provided above had not been completed in a sanitary manner and placed residents at risk for acquiring an infection. -She should have removed her gloves and washed or sanitized her hands after they had been soiled and prior to doing personal care. Interview on 2/26/20 at 1:06 p.m. with director of nursing A regarding the above observations revealed she: *Agreed the personal care above was not completed in a sanitary manner. *Agreed the process above had created the potential for the residents to have acquired an infection. *The CNA should have removed her gloves and sanitized her hands anytime they had been soiled. Review of the provider's March 2016 Handwashing policy revealed: *"The spread of infection will be curbed by proper and frequent handwashing." *"Always wash hands: -Before and after contact with each resident.	F 880		

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F 880	Continued From page 44 -After contact with soiled linen. -After contact with objects that have had resident contact and may be contaminated. -After caring for a resident or touching any items contaminated with spore-forming organisms such as C. Diff [clostridium difficile]." *A used or clean paper towel should have been used to turn the water faucet on and off. The faucet was considered dirty and would contaminate your hands.	F 880		

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E 000	Initial Comments Surveyor: 32355 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 2/24/20 through 2/27/20. Jenkin's Living Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Loren W. Diekman | President/CEO | 3/20/20

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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	435036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/25/2020

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/25/20. Jenkin's Living Center (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 2/26/20. Please mark an F in the completion date column for K225 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 225 SS=C	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Surveyor: 27198	K 225		F

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Loren W. Diekman | President/CEO | 3/20/20

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K 225	Continued From page 1 Based on observation and record review, the provider failed to provide conforming exit stairs for one of three exits (west stair) that did not have a landing. Findings include: 1. Observation at 3:16 p.m. on 2/25/20 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 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than	K 923	Oxygen cylinders that were noted to be in the occupational therapy area during the survey were moved to the Therapy Gym on 2/27/20. Oxygen cylinders that were noted to be stored in Room 310 during the survey were moved to Room 312 on 2-27-20. No oxygen cylinders will be stored in the facility within five feet of combustibles. Facility residents were not impacted by the findings for this deficiency. The Director of Maintenance provided education to Maintenance and nursing staff on 2/27/20 regarding the proper storage of oxygen cylinders and proximity to combustible materials. The Director of Maintenance will audit oxygen cylinder storage in the facility monthly for a period of 3 months to ensure that proper storage guidelines are being maintained. The Director of Maintenance will report audit results at monthly QAPI Committee meetings for review and recommendation.	2/27/20

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K 923	Continued From page 2 or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to protect medical gas storage as required for two randomly observed locations (occupational therapy storage room and room 310). Findings include: 1. Observation at 1:21 p.m. on 2/25/20 revealed oxygen cylinders stored directly adjacent to combustible materials in the occupational therapy storage room. The required five feet of separation between combustibles and oxygen storage in an area protected by automatic fire sprinklers was not maintained in that location. Interview with the environmental services director at the same time of the observation confirmed that finding. Failure to protect medical gas storage as required	K 923		

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K 923	Continued From page 3 increases the risk of death or injury due to fire. The deficiency affected one of thirteen smoke compartments. 2. Observation on 2/25/20 at 3:38 p.m. revealed oxygen cylinders stored directly adjacent to combustible materials in room 310. The required five feet of separation between combustibles and oxygen storage in an area protected by automatic fire sprinklers was not maintained in that location. Interview with the environmental services director at the same time of the observation confirmed that finding. Failure to protect medical gas storage as required increases the risk of death or injury due to fire. The deficiency affected one of thirteen smoke compartments. Ref: 2012 NFPA 99 Section 11.3.2.3	K 923		

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	435036	A. BUILDING 02 - BUILDING 02 B. WING _____	02/25/2020

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/25/20. Jenkin's Living Center (building 02) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 2/26/20. Please mark an F in the completion date column for K225 deficiency identified as meeting the FSES, in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 225 SS=C	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and record review, the provider failed to ensure conforming exit stairs for two of two stairs (east and west stairs) were not conforming. Findings include:	K 225		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Loren W. Diekman | President/CEO | 3/20/20

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING 02 - BUILDING 02 B. WING _____	02/25/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 225	Continued From page 1 1. Observation at 3:42 p.m. on 2/25/20 revealed the door swinging into the second-floor west stair enclosure reduced the landing to 21 inches. Observation at 10:42 a.m. on 2/25/20 also revealed the door swinging into the second-floor east stair enclosure reduced the landing to 11 inches. Document review of previous survey data confirmed those conditions. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.	K 225		

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 _____	02/25/2020

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 Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/25/20. Jenkin's Living Center (building 03) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Loren W. Diekman | President/CEO | 3/20/20

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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 _____	02/25/2020

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 Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/25/20. Jenkin's Living Center (building 04) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Loren W. Diekman | President/CEO | 3/20/20

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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 _____	02/25/2020

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 Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/25/20. Jenkin's Living Center (building 05) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Loren W. Diekman | President/CEO | 3/20/20

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.

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 _____	02/27/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/24/20 through 2/27/20. Jenkin's Living Center was found not in compliance with the following requirement: S210.	S 000		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on interview and record review, the provider failed to ensure three of five recently hired sampled employees (D, E, and F) had a health evaluation by a licensed health professional completed within fourteen days of	S 210	The Infection Control Nurse and H.R. Director revised the Employee TB Screening Tool, adding a checklist to determine that an employee is "free of communicable diseases". The Infection Control Nurse, or other licensed nursing personnel, will sign off on this document on an employee's first day of employment. All staff members could potentially be impacted by the findings for this deficiency. The Human Resources Director will audit employee personnel files for weekly for 4 weeks and then monthly for 3 months to ensure that an appropriate employee health screening has been completed. The H.R. Director will report results of audits at monthly QAPI Committee meetings for review and recommendation.	4/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Loren W. Diekman

TITLE: President/CEO

(X6) DATE: 3/20/20

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 _____	02/27/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 210	Continued From page 1 being hired. Findings include: 1. Interview and review on 2/26/20 at 3:35 p.m. of employees' personnel records with human resources (HR) director G revealed: *The following employees were hired on the following dates: -Employee D: 10/21/19. -Employee E: 9/3/19. -Employee F: 10/17/19. *The above employees' files had no evidence of health evaluations by a health care professional to determine they were free of communicable diseases. *HR director G indicated they used to have a form for the health evaluations that was quite lengthy. -They had decided to stop using the form several months ago and had not put a new one in place. *There was no policy on employee health evaluations. *Her expectation was to follow the regulation for a health evaluation to have been completed by a licensed health professional within fourteen days of an employee being hired.	S 210		
S 000	Compliance/Noncompliance Statement Surveyor: 27198 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 2/24/20 through 2/27/20 Jenkin's Living Center was found in compliance.	S 000		