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	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jenkin's Living Center	215 South Maple Street Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure that resident medications were secured by three of three licensed nurses, contracted travel licensed practical nurse (LPN) I, LPN M, and registered nurse (RN) nurse manager H, who left medication carts unlocked and unattended. Findings include: 1. Observation on 5/19/26 at 11:01 a.m. revealed registered nurse (RN) nurse manager H left the medication cart unlocked, in the nurse's station by the elevator and storage room marked room [ROOM NUMBER], during the fire drill. 2. Observation and interview on 5/20/26 at 8:19 a.m. outside of resident 9's room with contracted travel LPN I revealed there was a medication cart that was unlocked and no staff member was present. At 8:20 a.m., contracted travel LPN I returned to the medication cart and confirmed it was unlocked. She left the cart unlocked and went into the dining room to give a resident their medication. She stated that it was not her normal practice to leave the medication cart unlocked, had forgotten to lock it, and was away from it for a few minutes. 3. Observation on 5/20/26 at 8:53 a.m. revealed LPN I left the medication cart unlocked, in the nurse's station by the elevator and storage room marked room [ROOM NUMBER], until 9:10 a.m. when she returned to the cart. 4. Observation on 5/20/26 at 11:02 a.m. revealed LPN I left the medication cart unlocked, in the nurse's station by the elevator and storage room marked room [ROOM NUMBER]. LPN I then returned to the medication cart at 11:04 a.m. 5. Interview on 5/20/26 at 2:43 p.m. with LPN I revealed she knew she had left the medication cart unlocked and that it should be locked when she walked away from it. 6. Observation on 5/20/26 at 6:58 p.m. in the oak center unit revealed the medication cart was unlocked and unattended by any staff. There was two unidentified certified nursing assistants (CNAs) who walked past the medication cart during the observation. There were also four unidentified residents sitting four feet away from the medication cart in the television area. 7. Interview on 5/20/26 at 7:03 p.m. with LPN M revealed she had worked for the facility since December of 2025. She was the nurse in charge of the oak center unit for her scheduled shift which started at 6:00 p.m. She had just come from a resident's room and she confirmed the medication cart was left unlocked and that she had the medication cart keys. She acknowledged that the medication (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cart should always be locked when unattended. 8. Interview on 5/20/26 at 7:10 p.m. with RN G revealed she expected the medication cart to be locked whenever it was not attended by the nurse. 9. Review of the provider's revised July 2025 Medication Administration policy revealed 15. The medication cart should always be locked unless it is in direct view of the nurse/UAP [unlicensed assisted personnel].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. A. Based on observation, interview, and policy review, the provider failed to ensure infection control practices were followed by three of three observed certified nursing assistants (CNA) (D and E) and one of one registered nurse (RN) G when assisting three of four sampled residents (2, 6, and 44) with personal care.Findings include: 1. Observation on 5/20/26 at 8:45 a.m. of CNA D assisting resident 44 in his room revealed there was a sign on the resident's door that indicated he was on enhanced barrier precautions (EBP) (the implementation of personal protective equipment (PPE) which included the use of gloves, gowns, and masks to prevent the spreading of organisms). All staff had to wear a gown and gloves when assisting the resident. Without washing or sanitizing her hands, CNA D put on a gown and a pair of gloves before entering the resident's room. With those gloved hands, CNA D opened the resident's closet door, gathered clean clothes, and laid them on the resident's bed. She moved the resident's bed and the bedside table to make more room to assist him. She tore a garbage bag off a garbage bag roll that was lying on a dresser, opened it up, and placed it on the bed. She raised the resident's bed higher and removed the blanket covering the resident. She opened the bedside stand and took out a package of wet wipes, opened it, and laid it on the resident's bed. With those same gloved hands, CNA D opened the resident's incontinent brief (an absorbent, disposable undergarment worn to help with urine and bowel leakage), grabbed wet wipes, provided personal care, and assisted the resident to turn onto his left side. She grabbed more wet wipes and cleansed his rectal area and buttocks. She removed a bottle of cream from the bedside stand, opened it, put some on her right gloved hand, and applied it to his rectal area and buttocks. While wearing those same gloves, CNA D put a clean incontinence brief on resident 44 and placed Hoyer lift (device used to assist with transferring from one surface to another) sling underneath him with assistance from RN nurse manager H. CNA D moved the Hoyer lift over to the resident's bed, attached the sling to it and used the Hoyer lift remote to lift resident 44 off his bed an transfer him into his recliner. CNA D removed the sling from the lift, opened the resident's door, and pushed the Hoyer lift into the hallway. CNA D changed the resident's shirt, covered him with a blanket, and moved the bedside table closer to him. CNA D removed and discarded her gloves in a trash can, removed her gown, and washed her hands for the first time. 2. Observation on 5/20/26 at 12:30 p.m. of CNAs D and F with resident 44 in his room revealed that without washing or sanitizing their hands, both CNAs put on a gown and a pair of gloves. Both CNAs D and F moved the Hoyer lift closer to resident 44, repositioned the sling underneath the resident, and attached it to the Hoyer lift. CNA D removed the blanket that was covering the resident. She then used the Hoyer lift remote to lift the resident out of the recliner and assisted CNA F with transferring him onto his bed. After they had completed the transfer, they unhooked the sling from the lift and removed it from underneath the resident by rolling him back and forth in bed. CNA D opened resident 44's bedside stand drawer, took out a package of wet wipes, laid it on his bed covers, opened it, and pulled out several wipes. She tore a garbage bag off a garbage bag roll that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was lying on a bedside dresser, opened it, placed it on the bed, and raised the bed higher to assist the resident more easily. With those same gloved hands, both CNAs D and F lowered resident 44's pants to check his incontinent brief. He was incontinent with both urine and bowel. CNA D opened the resident's incontinent brief, removed some wet wipes, cleansed his front area, and then assisted the resident to turn onto his left side. She removed more wet wipes and cleansed his rectal area and buttocks. She retrieved a bottle of cream from the bedside stand, opened it, put some on her gloved right hand, and applied it to his rectal area and buttocks. While wearing the same gloves, CNA D put a clean incontinence brief on resident 44 and assisted CNA F with pulling up his pants, positioning him higher in his bed, covering him with a blanket, and attaching his call light to the side rail on his bed. CNA D moved the intravenous (IV) pole and IV tubing so that it was closer to the resident and his bed, and used the bed remote to adjust its height. She opened the resident's door and pushed the Hoyer lift out into the hallway. CNA D and F removed and discarded their gloves in the trash can, removed their gowns, and washed their hands for the first time. 3. Interview on 5/20/26 at 12:50 p.m. with CNA D regarding the above personal care observations with resident 44 revealed that it was her usual process. After reviewing the observed unsanitary processes with resident 44, she acknowledged that she should have changed her gloves and sanitized her hands when they were dirty. She further acknowledged that her process had the potential to create an infection for the resident. 4. Interview on 5/21/26 at 1:45 p.m. with director of nursing (DON) B regarding the observations of CNA D completing personal care with resident 44 revealed she expected hand hygiene (HH, washing and sanitizing hands) and glove changing to be done between each new task. Tasks included gathering supplies and touching items in the environment, which were dirty. Same with personal/perineal care, gloves should be changed after the completion of that task and sanitizing of hands prior to touching more items in the environment. She acknowledged that CNA D's process created the potential for an infection to occur for resident 44. 5. Observation on 5/21/26 at 11:18 a.m. of CNA E and contracted travel licensed practical nurse (LPN) I providing personal care to resident 6 in her room revealed resident 6 had a sign on his door indicating he was on EBP. CNA E and LPN I used alcohol-based sanitizer, put on a gown and a pair of gloves before entering resident 6's room. CNA E prepared wet washcloths, placed a yellow bag on the bedside table, and put the wet washcloths on top of the yellow bag. Resident 6 had personal items, which included (call light, open Gatorade container, blue water mug, and remote control) on top of his bedside table. Resident 6 was incontinent of bowel and had a urinary catheter (flexible tubing placed in the bladder to drain urine). After CNA E cleaned resident 6's rectal area with the wet washcloths, she put them in the yellow bag with the clean wet washcloths. CNA E placed resident 6's soiled incontinent brief on the bedside table on top of the clean washcloths. CNA E placed a soiled clothing protector that was on the resident's bed from the morning meal service over the yellow bag, as well as over the resident's drinking straw and mug with a drinking (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	straw. With those same gloved hands, she touched the resident's clean incontinent supplies, blankets, the resident's bedside table, and the tops of resident 6's open Gatorade bottle, water mug, bed remote, TV remote, and call light. 6. Interview on 5/20/26 at 11:45 a.m. with CNA E revealed that she did not clean the urinary catheter at all during resident 6'spersonal cares. She would normally clean that but did not do it that time. 7. Interview on 5/20/26 at 2:43 p.m. with contracted travel LPN I revealed that she expected the staff to change their gloves after cleaning the resident before cleaning other items. She expected the urinary catheter tubing to be cleaned during the resident's personal care. 8. Observation on 5/20/26 at 7:21 p.m. of RN G assisting with resident 2's urinary catheter care revealed that RN G put on a pair of gloves from the right-side pocket of her uniform. She removed and discarded those gloves after resident 2's cares were completed. Without washing her hands RN G touched two washcloths and two used alcohol pads that were positioned under the resident's catheter tubing used during the catheter cares and then touched the resident's bedside table. 9. Interview on 5/21/26 at 12:35 p.m. with LPN/infection preventionist (IP) P revealed she expected the staff to change their gloves after providing resident's perineal care and to wash their hands? before doing anything else. She stated, It is very inappropriate to touch the resident's personal items or drinking cups with the same gloves used during their perineal care. She would prefer that the dirty linen bags to be placed on the side of the bed, and not on the resident's bedside table. If the bedside table was used during the resident's personal care, there should be no personal items on the table at the same time.(add line space) LPN/IP P expected the staff to not touch, with bare hands, soiled wash cloths, or used alcohol pads before touching additional personal items. She expected hand hygiene to be completed in between tasks. 10. Review of the provider's reviewed June 2023 Infection Prevention and Control Manual Glove Technique (Non-Sterile) policy revealed Apply clean non-sterile gloves when touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin. [NAME] clean gloves between tasks and procedures on the same resident after contact with blood, body fluids, secretions, excretions. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. Perform hand hygiene after the removal of gloves. Key point: Do not carry gloves in the pocket of uniform or lab coat. 11. Review of the provider's reviewed September 2022 Infection Prevention and Control Manual Standard Precautions-Gloves policy revealed it is the policy of Jenkin's Living Center that gloves will be worn by employees when it is reasonably anticipated that their hands will come in contact with blood, other potentially infectious materials, mucous membranes, non-intact skin, contaminated equipment or surfaces. 12. Review of the provider's reviewed November 2025 Foley Catheter Management policy revealed 10. Clean the catheter tubing: a. Hold the catheter securely to avoid pulling. B. Wipe away from the body down the catheter tubing approximately 4-6 inches using smooth strokes. C. Do not tug or place tension on the catheter. 13. Remove gloves and perform hand hygiene. B. Based on observation, interview, and policy review the provider failed to ensure two of two Sara (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Steady (non-powered sit-to-stand mechanical lift used to assist from a seated to a standing position) mechanical lift devices, and three of four sit-to-stand (a battery powered mechanical lift used to assist from a seated to a standing position) mechanical lifts were disinfected between resident use. Findings include: 1. Observation on 5/19/26 at 10:25 a.m. revealed a Sara Steady mechanical lift dated 12-2024 was sitting in east hallway from oak center nursing station had food debris on the foot board, no Sani-wipes (disinfection wipes) were attached to the device. 2. Observation on 5/19/26 at 10:25 a.m. revealed outside resident 2's room there was a sit-to-stand numbered 412020 with food debris on the foot board, and was missing a safety clip on the right side of the latching hook. 3. Observation on 5/19/26 at 10:36 a.m. revealed there was a Sara Steady mechanical lift numbered 25 outside resident 8's room with food debris on the foot board with no disinfectant wipes for cleaning on the machine. 4. Observation on 5/19/26 at 4:10 p.m. revealed there was a Sara Steady mechanical lift in the hallway with torn areas on the black footboard. There was debris in these torn areas, making it an uncleanable surface. 5. Observation on 5/20/26 at 8:43 a.m. revealed there was a sit-to-stand in the hallway numbered 25, which had food debris on the footboard. 6. Observation on 5/20/26 at 9:05 a.m. revealed there was a sit-to-stand numbered 412020 with no clip on the right side of the latching hook and had with food debris and a white powdery substance on the foot board. 7. Observation on 5/20/26 at 9:08 a.m. revealed there was a numbered 25 sit-to-stand mechanical lift sitting outside resident 2's room which had food debris on the foot board and a white colored residue on the black grip pads on the footboard. 8. Observation on 5/20/26 at 9:11 a.m. revealed there was a numbered 19 sit-to-stand mechanical lift missing grip tape on left side of the foot board, and a brownish colored substance on the lower right corner of the foot board. 9. Observation on 5/20/26 at 9:14 a.m. revealed there was a Sara Steady mechanical lift device in the hallway outside resident 8's room that had a white powder substance on the foot board. There were torn areas on the left and right sides of the black foot board. Food debris was in those torn areas and made it an uncleanable surface. 10. Observation on 5/20/26 at 11:44 a.m. revealed that after observing resident 6's personal cares, CNA E did not clean the sit-to stand used and placed it back into the hallway. 11. Observation on 5/20/26 at 7:06 p.m. revealed there was a Sara Steady mechanical lift dated 5-26 that had a blue creamy substance on the footboard. 12. Observation on 5/21/26 at 7:50 a.m. revealed there was a sit-to-stand numbered 412020 with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	green tape on it numbered 124 in the hallway with food debris on the footboard. 13. Interview on 5/21/26 at 10:17 a.m. with CNA F revealed that mechanical lifts should be cleaned after each resident use. She cleaned any part of the lift that the resident touches. She agreed food debris on the foot boards should be cleaned off as well after a resident used the mechanical lift. 14. Interview on 5/21/26 at 11:22 a.m. with CNA Q revealed she used Sani-wipes to clean the mechanical lifts. When she was done with a mechanical lift transfer for a resident she would clean any surface that the resident touched, so it was ready to use on the next resident. She included the footboard as a space needing to be cleaned. She would notify maintenance by calling them or filling out a maintenance slip on the computer to notify them of needed repairs to the mechanical lifts. 15. Interview on 5/21/26 at 11:30 a.m. with LPN O revealed she expected the mechanical lifts to be sanitized with the Sani cloth wipes between resident use. If something needed to be fixed on the mechanical lifts, she would call for maintenance on the walkie or put in a work order. 16. Interview on 5/21/26 at 11:44 a.m. With contracted travel LPN I revealed she expected the mechanical lifts to be wiped down with the Sani cloths that were available on the lifts or at the nurse's station. If there was something that needed to be fixed, she would use the walkie to call for maintenance or fill out a work order. 17.Interview on 5/21/26 at 12:35 p.m. with LPN/IP P revealed that she expected the mechanical lifts to be wiped down with Sani cloths that were located on the lifts or at the nurse's station. The cleaning should be from top to bottom, including the footboards. The lifts were to be cleaned after each resident use before being placed back into the hallway. Once they were in the hallway, they were considered clean. 18.Interview on 5/21/26 at 2:30 p.m. with DON B revealed she expected the mechanical lifts to be wiped down with the Sani cloths after each use. 19. Review of the provider's reviewed August 2023 Infection Prevention and Control Manual Cleaning and Disinfection of Equipment/Devices policy revealed 7. Reusable equipment will not be used for the care of another resident until it has been appropriately cleaned and disinfected, and single-use items are properly discarded.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview, call light log documentation review, and policy review, the provider failed to ensure the staff responded promptly to one of two sampled residents (2) who reported being incontinent (involuntary urine or bowel leakage) while waiting for her call light to be answered.Findings Include: 1. Interview on 5/19/26 at 10:39 am with resident 2 revealed she had concerns that when the facility was short on staff, her call light was not answered quickly enough. She stated, we wait forever to get the call light answered. This caused her to be incontinent of bowel. She stated, she feels embarrassed and frustrated when this happens.2. Resident 2 admitted into the facility on 2/1/2021. Review of resident 2's electronic medical record (EMR) revealed her 4/7/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact.She had diagnoses of Hemiplegia (the inability to move or control the muscles) and hemiparesis (one side of a person's body is weak) affecting her left side, contracture (the muscles, tendons or skin becoming tight or stiff and permanently shortened, making it difficult to move a joint) of the left lower leg, and left foot drop (weakness or nerve damage makes it hard to lift the front part of the foot).Resident 2's care plan on 4/13/26 revealed she required substantial/maximum assistance from the staff with transfers. Staff were to monitor and document bowel sounds and frequency of bowel movements. Resident 2 was continent of bowel and had a suprapubic catheter (flexible tubing inserted in the lower abdomen placed directly in the bladder to drain urine) in place. 3. Review of resident 2's call light response time report (a summary of resident call-light activity and the staff time responses) from 5/5/26 through 5/20/26 revealed she had eleven call light response times over 20 minutes long and three call light response times over 30 minutes long.4. Interview on 5/21/26 at 9:02 a.m. with certified nursing assistant (CNA) revealed that she expected the resident's call lights to be answered within to within 5 minutes.5. Interview on 5/21/26 at 11:30 a.m. with licensed practical nurse (LPN) O revealed the facility's goal was to have call lights answered within 6 minutes, unless the staff were already helping someone else, then the expected call light response time was 15 minutes.6. Interview on 5/21/26 at 11:44 a.m. with LPN I revealed that she expected the call lights to be answered within 3-5 minutes.7. Interview on 5/21/26 at 2:30 p.m. with director of nursing (DON) B revealed that she expected the call lights to be answered within 12 to 15 minutes.8. Review of the provider's undated Call Light Response policy revealed to ensure residents receive timely assistance, maintain resident safety, uphold resident rights, and support quality care through prompt and appropriate response to all activated call lights. It is the policy of [NAME] Living Center that all resident call lights and assistance alarms will be answered promptly, court

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, manufacture instruction review, and policy review, the provider failed to ensure that two of three dish machines reached the minimum temperatures for the wash and rinse cycles before washing the dishes.Findings include:1. Observation and interview on 5/19/26 at 9:32 a.m. in the main kitchen with cook K revealed a sign on the commercial dish machine that read When taking temps [temperatures] on the dish machines, please make sure you are running the dish machine at least 3 times/or getting to the correct temp before recording a temp as some of them have sat without being ran so they need to get up to temp before using., signed by food service supervisor L. [NAME] K ran the first tray of dishes through the dish machine, and the wash temperature reached 142 degrees and the rinse temperature reached 164 degrees. For the second load of dishes that cook K ran through the dish machine the wash temperature reached 154 degrees, and the rinse temperature reached 186 degrees.When asked about the dish machine temperature cook K stated, that she needed to run the dish machine a couple of times to get to the minimum temperature. She confirmed she did not run the dish machine before she started to wash the dishes, and the dish machine did not reach the minimum temperature for the first load.2. Observation and interview on 5/20/26 at 8:40 a.m. in the second-floor kitchen with cook J revealed cook J ran a tray of dishes through the dish machine. The wash temperature reached 147 degrees, and the rinse temperature reached 177 degrees. [NAME] J stated the dish machine temperatures should reach a minimum of 150 degrees for the wash cycle and a minimum of 180 degrees for the rinse cycle. She did not usually run the dish machine, but the facility let an employee go and did not replace them, so now she cooks and helps with the dishes. 3. Interview on 5/20/26 at 8:52 a.m. with food service supervisor L regarding the dish machine temperatures revealed that the staff was educated on how to run the dish machines. The staff knew to run the dish machines a couple of times before running dishes through them, because water sits in the lines and they needed to run them to get the water up to the correct temperatures. There was a sign posted on the dish machine in the main kitchen to remind the staff to run it. She expected the staff to run the dish machines before washing the dishes. 4. interview on 5/21/26 at 10:07 a.m. with maintenance worker N regarding the dish machine temperatures revealed that maintenance was aware there was an issue with the temperatures for the dish machine in the main kitchen. He thought it was fixed when the heating element was replaced in that dish machine. The dietary staff did notify maintenance if there was an issue with kitchen equipment.5. Interview on 5/21/26 at 12:48 p.m. with administrator A regarding dish machine temperatures revealed that he confirmed the wash temperature needed to be 150 degrees or above and the rinse temperature needed to be 180 degrees or above. He expected the dietary staff to follow the manufacturer's instructions for the dish machines. He agreed the staff should have run the dish machines to get the temperature up before washing dishes.6. Review of the manufacturer's dish machine instruction revealed the hot water sanitizing wash temperature should be150 degrees Fahrenheit minimum, and a rinse temperature of 180 degrees Fahrenheit minimum.7. Review of the provider's 2021 Cleaning Dishes/Dish Machine policy revealed All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing.