

ORIGINAL

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

PRINTED: 09/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2016
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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428
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F 000	INITIAL COMMENTS Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/13/16 through 9/14/16. Bowdle Nursing Home was found not in compliance with the following requirements: F156, F280, F281, F323, and F441.	F 000	*Addendums noted with an asterisk per 10/26/16 per email with facility DON. HW/SDDOT/EL	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.	F 156		

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

TITLE

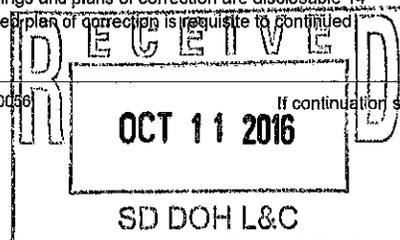
(X6) DATE

Sandra Schlerliter

CEO

10/06/2017

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 156	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p>	F 156		
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F 156	<p>Continued From page 2</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure the Notification of the Medicare denial process was accurately presented with the correct Centers for Medicare and Medicaid Services standardized forms for three of three sampled residents (2, 3, and 6). Findings include:</p> <p>1. Review of residents 2, 3, and 6's medicare records revealed: *They had received an Advance Beneficiary of Notice of Non-coverage (ABN) when their Medicare part A coverage had ended. *They had not received the Nursing Facility Advanced Beneficiary Notice (SNFABN) or the Notice of Medicare Provider Non-Coverage when their skilled coverage had ended. *The SNFABN form would have given them the option to have a demand bill issued (having their care reviewed to continue Medicare coverage).</p> <p>Interview on 9/14/16 at 8:30 a.m. with the social</p>	F 156	<p><i>*Social Service designee. (SSD) HW/SPDOH/EL</i></p> <p>This deficiency has the potential to affect all Medicare residents. The [redacted] will ensure that all Medicare residents receive the Skilled Nursing Facility Advanced Beneficiary Notice and the Notice of Medicare Provider Non-Coverage when their skilled coverage ends. The SSD will monitor compliance monthly. The SSD will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p><i>*Residents 2, 3, and 6 could not receive the current forms for when their skilled coverage ends as the medicare time frame has passed. Other residents were found to have the incorrect</i></p>	10/1/16
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F 156	Continued From page 3 service designee (SSD) revealed: *The ABN form was the only form she had available to use. *She had been in the SSD position for approximately two years. *She agreed she had used the incorrect form for all residents she had given notice of non-coverage to during that time. Review of the provider's 11/1/00 Medicare SNF Denial Letters policy revealed: *When notifying a resident or person acting on behalf of a resident that a determination of non-coverage had been made, the provider would utilize the appropriate SNF denial letter. *That signed letter would become part of the resident's medical record.	F 156	<i>*form. correct form will be utilized in the future. KW/SDDD/H/EL</i>	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans reflected the current status for one of nine sampled residents (2). Findings include:</p> <p>1. Review of resident 2's medical record revealed: *He had been readmitted to the facility on 6/6/16 from an acute care hospital stay. *Diagnoses included a cerebral vascular accident (CVA), dementia, cataracts, and Type II diabetes. *He had: -No muscle control on the right side of his body. -Required assistance from the staff for positioning, transfers, and eating. -A history of falls. -Changed his code status from a full code to a no code after his CVA on 6/27/16.</p> <p>Observation on 9/13/16 at 1:05 p.m. of certified nursing assistants (CNA) D and E with resident 2 revealed: *They had prepared to assist him out of his wheelchair and into his bed. *They had retrieved a transfer aide to use for transferring him into the bed. *His bed had two half side rails located at the top of his bed. *They laid him down in the bed with those side rails placed in the upright position. He had used those side rails to assist the staff with turning him onto his left side.</p>	F 280	<p>This deficiency has the potential to affect all residents. All care plans will be reviewed quarterly, if there is a significant change, and upon readmittance. The DON will monitor this monthly. The DON will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p><i>*The resident 2 care plan was updated to current function, code level, and use of side rails for positioning. All other care plans were audited and corrected. 10/10/16 meeting was held with staff by DON on care plans and side rail use. MDS coordinator/DON will update/monitor all care plans as needed monthly.</i></p> <p><i>KW/SDD/EL</i></p>	10/5/16
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F 280	<p>Continued From page 5</p> <p>*They placed a floor mat down on the left side of his bed.</p> <p>Interview on 9/13/16 at the time of the above observation with CNAs D and E regarding resident 2 revealed confirmed:</p> <p>*The resident required a transfer aide to help him with transfers. After his CVA he had not been able to stand on his legs.</p> <p>*He used the side rails to help the staff with moving him from side-to-side in the bed.</p> <p>*He had a history of falls out of his bed and required the use of a floor mat for safety.</p> <p>*His current code status should have been documented on his care plan.</p> <p>*The care plan and Kardex were the resources used to provide care for all of the residents. The Kardex had been considered a part of the care plan.</p> <p>Review of resident 2's 7/12/16 Kardex revealed:</p> <p>*He had been a full code.</p> <p>*He had not required the use of side rails.</p> <p>*He had a history of falls with no interventions for the staff to follow for safety.</p> <p>*No documentation he had required the use of a transfer aide.</p> <p>Review of resident 2's 7/12/16 care plan revealed:</p> <p>*Focused area: "High risk for falls r/t unsteady and balance problem and hemiplegia right side d/t CVA on 6/3/16."</p> <p>-Interventions under that focused area revealed no documentation he had required the use of a floor mat for safety.</p> <p>*Focused area: "ADL [activities of daily living] self care performance deficit r/t osteoarthritis and</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>cognition and CVA 6/3/16 with right side hemiplegia."</p> <p>-Interventions under that focused area revealed no documentation he had:</p> <p>--Required the use of a transfer aide.</p> <p>--Used side rails to help the staff position him in the bed.</p> <p>Interview on 9/13/16 at 1:30 p.m. with registered nurse (C) and the Minimum Data Set assessment coordinator revealed:</p> <p>*The interdisciplinary care team and nursing staff had been responsible for reviewing and revising the care plans.</p> <p>*They confirmed the resident care Kardex had been a part of the care plan.</p> <p>-The staff used them to guide their care for the residents.</p> <p>*They agreed:</p> <p>-All of the above areas of concern for resident 2 should have been found on his care plan and Kardex.</p> <p>-The care plan and Kardex should have been updated to reflect the current level of care he had required.</p> <p>Review of the provider's undated Advance Directives policy revealed:</p> <p>**"Changes of an advance directive must be submitted in writing to the social service department."</p> <p>**"The care plan team will be informed of such changes so that appropriate changes can be made in the resident assessment and care plan."</p> <p>Review of the provider's 2/28/13 Care Plans policy revealed "Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly."</p>	F 280		
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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 A. Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure nutritional interventions were in place in a timely manner for one of one sampled resident (2) who had a significant weight loss. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *He had been readmitted to the facility on 6/6/16 from an acute care hospital stay. *Diagnoses included a cerebral vascular accident (CVA), dementia, cataracts, and Type II diabetes. *He had: -No muscle control on the right side of his body. -Required assistance from the staff with eating. -Cavities and broken teeth. -Been pocketing his food since the CVA on 6/3/16 and required his food to be blended. -Been weighed weekly since his readmission on 6/6/16. *His readmission weight had been 161.8 pounds (lb). *A significant weight loss within eight days of readmission. -His weight had decreased to 151.2 lb by 6/15/16. *His weight continued to drop. -Within twenty days of readmission he weighed 149.8 lb on 6/26/16. That weight loss had been 7.4% since readmission.</p>	F 281	<p>This deficiency has the potential to affect all residents. The Dietary Manager reviewed this deficiency with the Registered Dietitian, the Certified Dietary Manager, and the nursing staff and arrived at the following plan of correction. The nursing staff and the Dietary Manager, under direction of the Registered Dietitian, will cooperate to prevent and intervene for any undesirable weight loss of the residents. The nursing staff will measure resident weights on admission, the next day, and weekly thereafter. If there is a weight change of greater than 5 pounds from one week to the next, the Dietary Manager will notify the nursing staff for the weight to be retaken the next day. (Continued on next page)</p>	
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F 281	<p>Continued From page 8</p> <p>-Within twenty-five days of readmission he weighed 148.5 lb on 7/1/16. That weight loss continued to be 7.4% or greater.</p> <p>*No documentation:</p> <p>-The nursing staff had been monitoring his weights or were aware of his weight loss.</p> <p>-The dietary manager (DM) had been aware of his weight loss until 6/30/16.</p> <p>-The registered dietician (RD) had been aware of his weight loss until 7/1/16.</p> <p>-A supplement for his weight loss had been initiated until 7/1/16.</p> <p>-The physician had been aware of his weight loss.</p> <p>Interview on 9/13/16 at 8:30 a.m. with the Minimum Data Set (MDS) assessment coordinator regarding resident 2 revealed:</p> <p>*He had:</p> <p>-A CVA in June and required more assistance from the staff.</p> <p>-A weight loss, but she was not aware of how much.</p> <p>*The MDS assessment coordinator had been unsure if the resident had been taking nutritional supplements for that weight loss.</p> <p>Observation on 9/13/16 at 11:40 a.m. of resident 2 revealed he had:</p> <p>*Been in the dining room eating his noon meal.</p> <p>*Required the staff to assist him with his food.</p> <p>*Not been observed pocketing his food.</p> <p>Review of resident 2's weight report revealed he weighed on:</p> <p>*6/6/16, 161.8 lb.</p> <p>*6/15/16, 151/2 lb.</p> <p>*6/26/16, 149.8 lb.</p> <p>*7/1/16, 148.5 lb.</p>	F 281	<p>If the weight change is verified, the Dietary Manager will notify the Registered Dietitian in writing within one day.</p> <p><i>[Redacted]</i> The Dietary Manager will monitor this weekly. The Dietary Manager will report to the QA Committee quarterly until the committee recommends to discontinue.</p> <p>*Nursing staff inputs the weight information into the EMR in which the DM reviews. After RD is notified of weight change, RD makes recommendations for nutrition changes, which goes to DM who notifies nursing. Nursing informs provider of the recommendations and makes order changes as they change. Resident 2 was referred to RD and recommendations were implemented. All residents will follow this procedure in the future.</p> <p><i>KW/SDDO/HJEL</i></p>	10/4/16	<i>KW/SDDO/HJEL</i>

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F 281	<p>Continued From page 9</p> <p>Review of resident 2's following MDS assessments revealed: *A 6/14/16 significant change in status MDS assessment revealed: -A weight of 162 lb. *A 6/30/16 Medicare 5 day MDS assessment revealed: -A weight of 150 lb. -Weight loss of 5% or more in the last month or 10% or more in the last six months indicated "Yes, not on physician-prescribed weight-loss regimen."</p> <p>Review of resident 2's MDS 6/14/16 Care Area Assessment nutritional documentation revealed: *He was to have received a diabetic with small portions diet. *The texture of the food had changed since his CVA. *He had not been identified as a potential for weight loss due to: -The change in food texture and consistency. -Recent pocketing of food since his CVA on 6/3/16. -The staff assistance needed to help him with his meal. -Missing some bottom teeth and there was the potential for cavities.</p> <p>Review of resident 2's dietary progress notes from 6/10/16 through 7/1/16 revealed: *The RD had been in the facility on: -6/10/16 and completed a readmission assessment for him. --He had not been identified as a weight loss at that time. --No interventions were planned. -7/1/16 and documented "Weight = 149.8 lb (6/26/16). Weight shows 7.4% loss x 30 days</p>	F 281		
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F 281	<p>Continued From page 10</p> <p>[significant]. Resident likely not meeting estimated needs. Will try offering 4 oz Ensure Plus BID between meals."</p> <p>*No documentation from the DM until 6/23/16.</p> <p>-She had identified the resident's feeding ability and level of staff assistance had changed.</p> <p>*There was no documentation the DM:</p> <p>-Had been monitoring the resident's weights and identified a concern.</p> <p>-Had communicated with the RD, nursing staff, or physician regarding his weight loss.</p> <p>Review of resident 2's nutritional assessments revealed no areas of concern or weight loss identified until 6/30/16. The RD had been notified. That had been twenty-four days after a significant weight loss had occurred.</p> <p>Review of resident 2's nursing progress notes from 6/6/16 through 9/13/16 revealed no documentation to support:</p> <p>*His weights had been monitored.</p> <p>*He had been weighed and reweighed per the provider's policy.</p> <p>*The physician had been notified of his weight loss and current interventions.</p> <p>*Any communication had occurred between the DM, RD, and nursing staff regarding his weight loss.</p> <p>Review of resident 2's physician's orders from 6/6/16 through 8/25/16 revealed no documentation his weight loss had been identified as an area of concern.</p> <p>Review of resident 2's 6/21/16 care conference log revealed no documentation his 10.6 lb weight loss from 6/6/16 through 6/15/16 had been identified.</p>	F 281		

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F 281	<p>Continued From page 11</p> <p>Review of resident 2's 7/12/16 documentation to support a nutritional supplement for his weight loss had not been initiated until 7/1/16.</p> <p>Interview on 9/13/16 at 3:30 p.m. with the director of nursing (DON) regarding resident 2 revealed: *She had confirmed: -The above medical record review for the resident. -He was nutritionally at risk for weight loss. -His weight loss had not been identified in a timely manner. -The nursing staff and DM should have identified his potential for weight loss at the time of his readmission. *She had not been aware: -The nursing staff and DM were not monitoring his weights according to the provider's policy. -The physician was not informed of his weight loss. *She stated "He fell through the hoops. He should have been reweighed the next day when there was more than a 5 lb weight change. The nurses should have identified it and reported it to the dietary department or started a supplement." *There was no nutritional at risk meeting or committee to address and identify those residents at risk for weight loss.</p> <p>Interview on 9/14/16 at 8:30 a.m. with the DM revealed: *She had been training for the CDM position since March 2016. *She: -Had not been aware she was to have monitored all of the residents' weights weekly. -Had been checking the residents' weights for MDS assessments only.</p>	F 281		
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F 281	<p>Continued From page 12</p> <ul style="list-style-type: none"> -Would not have recommended a supplement unless the weight loss was critical. -Had not been aware resident 2 had a significant weight loss within eight days of his readmission. -Had not identified his weight as an area of concern and he was nutritionally at risk until 6/30/16. That had been twenty-four days after a significant weight loss had occurred. -Was able to contact the RD at any time with questions and concerns. <p>Interview on 9/14/16 at 8:45 a.m. with the CDM revealed:</p> <ul style="list-style-type: none"> *She had confirmed the DM had been training for her position and she was her mentor. *She had not been aware the DM was not monitoring the residents' weights weekly. *She stated "Its on us if those weights are not monitored. You cannot rely on the nursing staff to always catch those weight problems. The nurses are suppose to watch their weights to." *She confirmed when there was a significant weight loss the nursing department, DM, RD, and physician should all have been involved to ensure the appropriate interventions were put in place. *She agreed resident 2: <ul style="list-style-type: none"> -Should have been identified nutritionally at risk at the time of his readmission. -Weight loss had not been identified in a timely manner. -Should have had nutritional supplements in place before 7/1/16. <p>Review of the provider's April 2007 Weight Assessment and Intervention policy revealed:</p> <ul style="list-style-type: none"> **The nursing staff and the Dietitian will cooperate to prevent, monitor, and intervene for undesirable weight loss for our residents." **The nursing staff will measure resident weights 	F 281			

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F 281	<p>Continued From page 13</p> <p>on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly." **Any weight change of greater than or less than 5 pounds within 30 days will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. The Dietitian will respond within 24 hours of receipt of written notification." **The Dietitian will also review the unit weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be assessed and addressed by the Dietitian whether or not the definition of Significant Weight Change is met."</p> <p>Interview on 9/14/16 at 9:00 a.m. with the DON regarding the above policy revealed "I thought they were to be weighed more often than that. That's not right."</p> <p>Review of the provider's April 2007 Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol policy revealed: **The nursing staff will monitor and document the weight and nutritional status of residents in a format which permits readily available month-to-month comparisons." **As part of the initial assessment, the staff and physician will define the individual's current nutritional status." **The staff will report to the physician significant weight gains or losses or any abrupt or persistent decline from baseline appetite or food intake." *The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, and prognosis."</p>	F 281		
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F 281	<p>Continued From page 14</p> <p>Review of the provider's 6/1/96 Registered Nurse/LPN-Charge Nurse job description revealed:</p> <p>***Supervises planning and administration of all nursing care working directly with assigned nursing staff in the provision and maintenance of high quality resident care.</p> <p>***Assume responsibility for coordinating each resident' medical and nursing regime; discussing resident's condition and sharing pertinent information with others involved in resident's care."</p> <p>Review of the provider's 10/15/97 Dietary Department Head job description revealed:</p> <p>***Coordinates the planning, preparing, and serving of regular and special diet meals to residents."</p> <p>"Counsels patients [residents] on special diets and insure nutritional assessments done on a timely basis."</p> <p>***Responsible to report significant changes and concerns to consultant dietitian monthly."</p> <p>***Provides nutrition counseling as ordered by the physician."</p> <p>***Works to develop cooperation with dietary staff and other nursing home personnel."</p> <p>Surveyor: 29162</p> <p>B. Based on record review, observation, interview, and policy review, the provider failed to ensure prescription medication had been administered to two of six sampled residents (5 and 6) by authorized personnel. Findings include:</p> <p>1. Review of resident 5's medical record revealed:</p>	F 281		
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F 281	<p>Continued From page 15</p> <p>*A physician's order on the September 2016 medication administration record for topical "Silver sulfadiazine 1% Cr 25 GM" for skin irritation. -"May be kept in shower room-for staff to administer."</p> <p>Observation on 9/13/16 of the shower room revealed a three tiered shelf sitting beside the bath tub. On the top shelf of the cart was a box with several containers of creams and ointments in it. One of those containers had been for resident 5. There was a pharmacy label on that container that stated her name, prescription number, and medication name of "SSD/OXIST/ELIDEL 1:1:1 CRE" (silver sulfadiazine).</p> <p>Interview on 9/13/16 at 4:30 p.m. with the director of nurses revealed: *Resident 5's prescription silver sulfadiazine cream should not have been kept in the tub room. *Application of the prescription silver sulfadiazine to resident 5 was not within the scope of practice of the staff that gave her a bath. *Only a licensed nurse should have been applying the topical medication for resident 5.</p> <p>Review of the provider's last reviewed/ revised 1/14/13 Administration and Documentation of Medications policy revealed: **"Only persons licensed or permitted by the state are allowed to prepare, administer and document the administration of medications." *Medications and biologicals must be kept locked up.</p> <p>Surveyor: 26632 2. Review of resident 6's medical record revealed:</p>	F 281	<p>*All medications have been removed from resident 5 and the room and tub room. All nursing staff were educated on 10/10/16 by DON and policy and procedure was reviewed. DON will monitor that all residents are evaluated and medications removed accordingly.</p> <p>KW/SDDOTHEL This deficiency has the potential to affect all residents. The policy for bedside meds was reviewed and will be monitored according to facility policy. The DON will monitor this monthly. The DON will report results to the QA Committee quarterly until the committee recommends to discontinue.</p>	10/5/16	

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F 281	Continued From page 16 *A 9/12/16 physician's order for topical "Mycostatin Pwdr apply QID [four times a day] to abdominal folds and affected areas." **"May be kept at bedside for staff to administer." Observation on 9/13/16 of resident 6's room with licensed practical nurse A revealed a container of mycostatin powder in the top dresser drawer. She confirmed it was there for staff to apply. She confirmed certified nursing assistants were the staff applying it and not licensed nurses. Interview on 9/14/16 at 9:30 p.m. with the DON revealed: *Resident 6's prescription mycostatin powder should not have been kept in the resident's room. *Application of the prescription mycostatin powder to resident 6 was not within the scope of practice of the staff that gave her a bath. *Only a licensed nurse should have been applying the topical medication for the resident.	F 281			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, record review, and interview, the provider failed to assess five of nine	F 323			

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F 323	<p>Continued From page 17</p> <p>sampled residents (2, 3, 4, 6, and 9) with siderails on their beds for safety. Findings include:</p> <p>1. Observation on 9/13/16 at 8:15 a.m. revealed resident 4 had half siderails on her bed.</p> <p>Review of resident 4's complete medical record revealed: *Half siderail use for positioning had been mentioned on her current working care plan. *There had been no assessment she had been able to use siderails safely.</p> <p>2. Observation on 9/13/16 at 4:30 p.m. revealed resident 9 had half siderails on his bed.</p> <p>Review of resident 9's complete medical record revealed: *"Half rails for positioning" had been written on his current revised 6/28/16 care plan. *There had been no assessment he had been able to use siderails safely.</p> <p>Surveyor: 32355</p> <p>3. Observation on 9/13/16 at 1:05 p.m. of certified nursing assistants (CNA) D and E with resident 2 revealed: *They had prepared to assist him out of his wheelchair and into his bed. *They had retrieved a transfer aide to use for transferring him into the bed. *His bed had two half side rails located at the top of his bed. *They laid him down in the bed with those side rails placed in the upright position. He had used those side rails to assist the staff with turning him onto his left side.</p> <p>Review of resident 2's complete medical record</p>	F 323	<p>This deficiency has the potential to affect all residents. A policy was written regarding the use of side rails for positioning and safety measures. The DON will monitor all residents' beds and care plans monthly. The DON will report results to the QA committee quarterly until the committee recommends to discontinue.</p> <p><i>*Residents 2, 3, 4, 6 and 9 were reviewed per policy for use of siderails. All residents were evaluated for side rails. 10/10/16 a meeting was had and education was provided. HW/SDDOHT/EL</i></p>	10/5/16	

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F 323	<p>Continued From page 18</p> <p>revealed:</p> <p>*No documentation in his 7/12/16 Kardex and care plan to support he required the use of side rails.</p> <p>*There had been no assessment completed to support:</p> <p>-He required the use of side rails.</p> <p>-He had been able to use the side rails safely.</p> <p>*No documentation the staff had:</p> <p>-Educated him and his family regarding safety concerns when using side rails.</p> <p>-Obtained permission from him and/or his family to use the side rails.</p> <p>Surveyor: 26632</p> <p>4. Observation and interview on 9/13/16 at 10:30 a.m. with resident 3 in her room revealed:</p> <p>*A half side-rail on the outside of her bed.</p> <p>*She stated she did not use that side-rail for assistance.</p> <p>Review of resident 3's 6/16/16 Kardex and care plan revealed no information on her use of the half side-rail on her bed.</p> <p>5. Observation on 9/13/16 at 8:30 a.m. of resident 6's room revealed half side-rails on each side of her bed.</p> <p>Review of her 7/7/16 Kardex and care plan revealed:</p> <p>*On her Kardex "Half rails for positioning at noc."</p> <p>*On her care plan "Side Rails: _____ (resident 6's name) uses half rails for repositioning and to assist with bed mobility."</p> <p>Surveyor 32573</p> <p>Interview on 9/14/16 at 9:30 a.m. with the director</p>	F 323		

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F 323	Continued From page 19 of nursing revealed: *She had been unaware siderail assessments should have been done. *There had not been siderail assessments done for safety on any resident. *They did not have a specific siderail policy.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441			

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F 441	<p>Continued From page 20</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>Surveyor: 29162 Surveyor 32573. Based on observation, interview, and policy and procedure review, the provider failed to ensure: *Sanitary conditions were maintained while performing personal care for one of one sampled resident (2) by two of two certified nursing assistants (CNA) D and E. *One of one sampled residents (8) observed during a breathing treatment had his hand-held nebulizer cleaned by LPN (A) after use. *Hand hygiene had been completed by one of one observed LPN (B) during one of one randomly observed resident's(1) treatment. Findings include:</p> <p>Surveyor: 32355 1. Observation on 9/13/16 at 1:05 p.m. of CNAs D and E while they provided care for resident 2 revealed: *They prepared to assist the resident with laying down in his bed. *They both sanitized their hands and put gloves on. *With those gloves on they: -Pushed the wheelchair closer to the transfer aide.</p>	F 441	<p><i>*All staff education was completed on 10/10/16 by DON. KW/SDDOHEL</i></p> <p>This deficiency has the potential to affect all residents. The policy and procedure regarding glove use and hand hygiene was reviewed with all staff members. The DON will perform competencies monthly. The DON will report results to the QA committee quarterly until the committee recommends to discontinue.</p>	10/5/16
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F 441	<p>Continued From page 21</p> <ul style="list-style-type: none"> -Placed a sling underneath him to assist with transferring. -Hooked that sling up to the transfer aide. -Assisted the resident to lay down on his bed. -Pulled the resident's slacks down. *CNA E continued to wear those soiled gloves when she: <ul style="list-style-type: none"> -Opened the closet door and retrieved a clean incontinent brief. -Opened a drawer on his bedside table and retrieved a package of wet wipes. -Removed his soiled incontinent brief. -Opened the package of wet wipes and retrieved several wipes. -Cleansed the front part of his perineal area. *CNA D retrieved several wet wipes and cleansed his bottom. *Both CNAs D and E continued to wear those soiled gloves when they: <ul style="list-style-type: none"> -Put a clean incontinent brief on the resident. -Applied lotion to his legs prior to pulling up his slacks. *CNA D: <ul style="list-style-type: none"> -Placed a pillow behind his back and between his knees. -Covered him with a blanket. -Removed her gloves and then sanitized her hands. *CNA E: <ul style="list-style-type: none"> -Placed the call light within reach for him. -Removed her gloves and then sanitized her hands. <p>Interview on 9/13/16 at the time of the observation with CNAs D and E revealed:</p> <ul style="list-style-type: none"> *That had been their usual process when providing personal care for the residents. *They agreed: <ul style="list-style-type: none"> -The process above had not been performed in a 	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/14/2016
NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428		
(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 441	<p>Continued From page 22</p> <p>sanitary manner.</p> <p>-The process they used had created the potential for cross-contamination of bacteria from one resident to another.</p> <p>--Resident 2 had shared a room, clothes closet, and bathroom with resident 1.</p> <p>Interview on 9/13/16 at 1:30 p.m. with the director on nursing (DON) revealed:</p> <p>*Personal care for resident 2 had been done incorrectly.</p> <p>*The above process had not been completed in a sanitary manner.</p> <p>*She agreed the CNAs had created the potential for cross-contamination of bacteria to the resident.</p> <p>Review of the provider's March 2004 Handwashing/Hand Hygiene policy revealed:</p> <p>**The purpose of this procedure is to provide guidelines to employees for proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infection."</p> <p>*Hand washing and sanitizing must occur under the following conditions:</p> <p>-"After handling items potentially contaminated with body fluids."</p> <p>-"Before moving from a contaminated body site to a clean body site during resident care."</p> <p>Surveyor: 29162</p> <p>2. Observation on 9/13/16 from 1:00 p.m. through 1:20 p.m. of LPN A when she administered a nebulizer treatment for resident 8 revealed she did not clean the nebulizer equipment after it was used.</p> <p>Interview on 9/13/16 at 4:15 p.m. with LPN A</p>	F 441	<p>*Hand Hygiene and glove use competencies will be done monthly with all nursing staff. Resident 8 nebulizer cleaning will be monitored 2x/wk on various shifts. All residents using nebulizers will be monitored on the same schedule by DON.</p> <p>KW/SDDO/H/EC</p> <p>This deficiency has the potential to affect all residents. The policy and procedure regarding nebulizer cleaning was reviewed by the nursing staff. The nursing staff is responsible to clean nebulizers per policy. The DON will monitor this monthly. The DON will report results to the QA committee quarterly until the committee recommends to discontinue.</p>	10/5/16	

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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428
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F 441	<p>Continued From page 23</p> <p>confirmed she did not clean resident 8's nebulizer equipment after it had been used. She stated "He is cognitively able to do his own treatment so I think he cleans it too."</p> <p>Interview on 9/13/16 at 5:00 p.m. with resident 8 regarding the cleaning of his nebulizer equipment revealed he did not clean it himself.</p> <p>Interview on 9/14/16 at 9:30 a.m. with LPN B revealed she did not clean any of the residents' nebulizers on a regular basis. She stated "Sometimes I take a tissue and wipe them out."</p> <p>Interview on 9/14/16 at 10:00 a.m. with the DON confirmed the nurses should have been cleaning the residents' nebulizers after they had been used.</p> <p>Review of the provider's January 2014 Respiratory Equipment Accessories policy revealed: *After each treatment the equipment was to have been: -Washed with warm soapy water and rinsed with cold tap water. -Allowed to air dry. *Daily at night the equipment was to have been: -Soaked "For 30 minutes in a 1:3 parts mixture of white vinegar and water." -Rinsed under cold water. -Allowed to air dry.</p> <p>3. Observation on 9/14/16 at 8:20 a.m. of LPN B while she changed a dressing for resident 1 revealed she: *Took her gloves off after she removed the soiled dressing. *Put on clean gloves and applied the clean</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428		
(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 441	<p>Continued From page 24 dressing. *Did not sanitize her hands between dirty and clean glove use.</p> <p>Interview on 9/14/16 at 10:00 a.m. with the DON confirmed LPN B should have sanitized her hands between dirty and clean glove use.</p> <p>Review of the provider's last revised March 2004 MED-PASS, Inc. Handwashing/Hand Hygiene policy revealed hands were to have been sanitized: *After contact with nonintact skin. *After removing gloves.</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2016
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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/13/16. Bowdle Nursing Home 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 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K046 and K050 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 10/27/16 per telephone with facility administrator. CH/SDDOH/EL	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on record review and interview, the provider failed to conduct quarterly fire drills each quarter for the three shifts during three of the four previous quarters for the twelve month period beginning October 2015. Findings include:	K 050	This deficiency has the potential to affect all residents. The maintenance supervisor will conduct fire drills as follows: 1st month of the quarter on the AM shift; 2nd month of the quarter on the PM shift; 3rd month of the quarter on the night shift. The maintenance supervisor will monitor monthly to ensure that the drills are completed one drill per shift per quarter. The maintenance supervisor will report results quarterly to the QA committee until the committee recommends to discontinue.	10/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lander Schlechter TITLE: CEO (X6) DATE: 10/07/2016

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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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428
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K 050	<p>Continued From page 1</p> <p>1. Fire drill record review at 2:00 p.m. on 9/13/16 revealed no documentation indicating a fire drill was conducted for:</p> <ul style="list-style-type: none"> *The third shift (10 p.m.-6 a.m.) during the fourth quarter of 2015 (October through December). *The first and second quarters of 2016 (January through March, April through June). *The second shift (3 p.m. - 11 p.m.) during the first quarter 2016 (January through March). *The first shift (6:00 a.m. - 2:00 p.m.) during the fourth quarter of 2015 (October through December). <p>Interview with the maintenance supervisor at 3:00 p.m. on 9/13/16 revealed he was unaware fire drills were not held as required for those above identified shifts each quarter.</p> <p>B. Based on observation and interview the provider failed to properly conduct a fire drill procedure during the onsite fire drill scenario. Findings include:</p> <p>1. Observation at 3:30 p.m. on 9/13/16 during the onsite fire drill revealed staff involved in the fire drill did not follow the provider's fire drill policy. Upon hearing the code red over the paging system and fire alarm activation staff began closing resident room doors. Staff however did not clear the corridor of soiled linen carts and lifts.</p> <p>The corridor shall be cleared of obstruction in the event that fire and rescue personnel deem it necessary for evacuation. Obstructions in the corridor during life rescue and evacuation operation could impede rescue personnel and creates a life safety hazard.</p> <p>Interview with the staff upon completion of the</p>	K 050	<p>This deficiency has the potential to affect all residents. The maintenance supervisor will instruct staff that all items must be removed from the hallways as they are conducting fire emergency plan. The maintenance supervisor will monitor staff during fire drills to ensure that all items are removed from the corridors. The maintenance supervisor will report results to the QA committee quarterly until the committee recommends to discontinue <i>*CHSDDCH/E</i></p>	
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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428	
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K 050	<p>Continued From page 2</p> <p>above fire drill revealed the things in the corridors were usually removed. They were unsure why those things had not been removed during this fire drill scenario.</p> <p>C. Review of the previous life safety survey dated 6/30/15 revealed the same above issues were cited (missing drills and equipment left in the corridor) during the fire drill conducted during that inspection.</p> <p>The deficiency had the potential to affect 100% of the occupants of all smoke compartment.</p>	K 050		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435107	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 9/13/2016
NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
K 046	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Surveyor: 18087</p> <p>Based on observation, testing, and interview, the provider failed to maintain emergency lighting of at least 90 minute duration. The emergency light in the boiler room was not working properly Findings include:</p> <p>1. Observation and testing at 9:00 a.m. on 9/13/16 revealed the battery pack emergency lighting installed in the boiler room would not function upon activation of the test button Interview with the maintenance supervisor at the time of the observation confirmed that condition He further revealed he had not performed preventative maintenance to check the emergency lights that were mounted higher in the building</p> <p>The deficiency affected one of numerous requirements for emergency lighting.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10596	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2016
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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH ST POST OFFICE BOX 556 BOWDLE, SD 57428
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S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/13/16 through 9/14/16. Bowdle Nursing Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/13/16 through 9/14/16. Bowdle Nursing Home was found in compliance.	S 000		

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

Sandra Schlecter

TITLE

CEO

(X6) DATE

10/07/2016

STATE FORM

6859

HOBL11

If continuation sheet 1 of 1

