STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWDLE NURSING HOME	8001 W 5TH STREET POST OFFICE BOX 556, BOWDLE, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/11/26 through 8/13/26. Bowdle Nursing Home was found not in compliance with the following requirements: F550, F655, F657, F727, F732, F755, F761, F812, and F880.	F0000		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on Payroll Based Journal (PBJ) reports, interview, employee timecard review, schedule review, and facility assessment review, the provider failed to ensure a registered nurse (RN) was scheduled for eight consecutive hours of coverage for one day in quarter two (January 1 through March 31) of fiscal year 2026 and six of thirty-one days in July 2026. Findings include: 1. Review of the PBJ report for quarter two of fiscal	F0727	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice.	09/04/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CEO	9-1-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

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F0727 SS = F	Continued from page 1 year 2026 revealed the provider did not have RN coverage for eight consecutive hours on 3/1/26, 3/14/26, 3/17/26, and 3/28/26. 2. Interview on 8/11/26 at 8:55 a.m. with assistant director of nursing (ADON) C during the facility entrance conference revealed that the provider had a waiver from 3/7/25 through 3/6/26 from the Center for Medicare and Medicaid Services (CMS) that exempted them from the requirement of an RN being in the facility for eight consecutive hours every day. The provider reapplied for that waiver did not receive confirmation from CMS if the waiver renewal was granted. 3. Review of the employee timecards for March 2026 revealed that the provider did not have RN coverage for eight consecutive hours on 3/28/26. 4. Review of the July 2026 employee schedule revealed there was no RN scheduled to work on 7/4/26, 7/5/26, 7/18/26, 7/19/26, 7/25/26, and 7/26/26. 5. Interview and review of the July 2026 employee schedule on 8/13/26 at 9:42 a.m. with ADON C revealed that ADON C verified there was no RN coverage for eight consecutive hours on 7/4/26, 7/5/26, 7/18/26, 7/25/26, and 7/26/26. 6. Review of the provider's 7/29/26 Facility Assessment revealed, "the [redacted name] has applied for and been granted a Waiver of Nursing Staff Requirements effective March 7, 2025.	F0727	3. The Director of Quality and Compliance submitted an application for Waiver of Nursing Staff Requirements to CMS on 02/26/26, per request. Director of Quality and Compliance submitted and application for Waiver of Nursing Staff Requirements to SD DOH on 04/29/26, per request. A RN Waiver Approval letter was received on 08/25/2026 from CMS. This waiver is effective 8/25/26-8/25/27. The Director of Quality and Compliance requested information from CMS regarding next years renewal process on 8/25/2026. The Director of Quality and Compliance requested information from the SDDOH regarding next years renewal process on 8/28/2026. This facility will follow that guidance when it is received. 4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will audit staffing data to ensure 40 hours of RN coverage weekly. 5. The results of these audits will be reported quarterly, reviewed, and trended for compliance and further follow up through the facility QAPI committee.	
F0655 SS = E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F0655	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice.	09/04/2026

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BOWDLE NURSING HOME	8001 W 5TH STREET POST OFFICE BOX 558, BOWDLE, South Dakota, 57428

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F0655 SS = E	Continued from page 2 (I) Be developed within 48 hours of a resident's admission. (II) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed with and a copy offered to the resident or	F0655	3. The current care plan process policy and procedure was reviewed and updated by the DON and CEO on 8/26/26. All residents and/or representatives will receive a baseline care plan within 48 hours of admission. This will be documented on the Care Plan Participation Form in an added 48 hour notification area. This form is then scanned into the resident's chart. The DON educated all nursing home staff regarding the new policy and procedure at the 8/27/2025 staff meeting. Any staff not in attendance will receive education and sign acknowledgment by 9/4/26. 4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON will audit all new admission charts on a weekly basis from 8/26/2026 going forward. 5. The results of these audits/observations will be reported monthly, reviewed and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	

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F0655 SS = E	Continued from page 3 the resident's representative within 48 hours of admission to the facility for four of five newly admitted residents (1, 4, 6, and 30). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 6/24/26. There was no documentation that resident 1's baseline care plan was reviewed with her or her representative, and a copy was offered to her or her representative within 48 hours of her admission to the facility. 2. Review of resident 6's EMR revealed she admitted to the facility on 7/1/26. There was no documentation that resident 6's baseline care plan was reviewed with her or her representative, and a copy was offered to her or her representative within 48 hours of her admission to the facility. 3. Review of resident 4's EMR revealed he admitted to the facility on 6/24/26. There was no documentation that resident 4's baseline care plan was reviewed with him or his representative, and a copy was offered to him or his representative within 48 hours of his admission to the facility. 4. Review of resident 30's EMR revealed he admitted to the facility on 7/6/26. There was no documentation that resident 30's baseline care plan was reviewed with him or his representative, and a copy was offered to him or his representative within 48 hours of his admission to the facility. 5. Interview on 8/12/26 at 2:05 p.m. with assistant director of nursing (ADON) C regarding reviewing and offering a copy of the resident's baseline care plan with the resident or their representative revealed that resident 4's spouse was provided with his comprehensive care plan, and resident 30's guardian could not be reached. She stated the comprehensive care plan was provided at the first scheduled care conference approximately 21 days after each resident's admission. She was aware that a resident's baseline care plan was to be completed within 48 hours of admission to the facility, but was not aware that it should have been reviewed with the resident or their representative and a copy offered to them. 6. Telephone interview on 8/13/26 at 12:45 a.m. with social service designee (SSD) I, revealed that the director of nursing (DON) B started the resident's baseline care plan at the time the resident admitted to the facility. The resident's comprehensive care	F0655		

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F0655 SS = E	Continued from page 4 plan was reviewed with the resident or their representative, "about" 14 days after the resident admitted to the facility, at that resident's care conference. The resident or their representative would be offered a copy of the resident's comprehensive care plan at that time. The resident or their representative would discuss what they would like to add to the comprehensive care plan during those care conferences. She was not aware that the baseline care plan should have been reviewed with the resident or their representative within 48 hours of admission. 7. Interview on 8/13/26 at 2:06 p.m. with director of nursing (DON) B and ADON C revealed that DON B stated she was aware the baseline care plan was to be completed and reviewed with the resident or their representative, and a copy offered to them, within 48 hours of the resident's admission. 8. Review of the provider's 2001 Care Plans – Baseline policy revealed "A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission." "The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) ..." "Provision of the summary to the resident and/or representative is documented in the medical record."	F0655	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. The current Handwashing/Hand Hygiene policy was reviewed and updated by the DON and CEO on 8/19/26. All nursing home staff were educated and supplied this updated policy on 8/27/26. Any staff not in attendance and dietary staff will receive education and sign acknowledgment by 9/4/26. Hand hygiene competencies will be completed by 9/4/2026.	09/04/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812		

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F0812 SS = E	Continued from page 5 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, revealed the provider failed to ensure the staff follow standard food safety regarding hand hygiene and glove use by three of three observed employees (O, R, and an unidentified employee) during one of one meal service. Findings include: 1. Observation on 8/11/26 11:13 a.m. of activity director R serving the noon meal to the residents in the dining room revealed that she had gloves on. She carried a tray with a resident's meal on it from the steam table to the table. She removed the plate, drink cups, and other dishes from the tray and placed them on the table in front of the resident. With those same gloved hands, she walked back near the steam table, tucked her hair behind her ear, picked up another meal tray from the steam table, walked into the dining area, and placed those dishes of food in front of resident 27. She then placed a clothing protector on resident 27, picked up the top bun off his cheeseburger, opened a packet of ketchup, put the ketchup on his cheeseburger, reapplied the top bun, walked back into the kitchenette, removed her gloves, put those gloves in the trash can, washed her hands, and put on a new pair of gloves. Activity director R then removed a tray of food from the steam table and set those dishes of food in front of resident 3. Without removing her gloves or performing hand hygiene she returned to the steam table, took a tray of food from the steam table to resident 19 and placed those dishes of food in front of him. Activity director R picked up the top bun off resident 19's cheeseburger, opened a packet of ketchup, placed ketchup on his burger, and replaced the bun on top of his burger. She then went into the kitchenette, picked up a package of ketchup, and returned to resident 19's table. With those same gloved hands she picked up the top bun from resident 19's second cheeseburger, opened the ketchup packet, put ketchup on that burger, and then put the top bun on his cheeseburger. With those same gloved hands she returned to the	F0812	4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will audit hand hygiene during one meal serving a day for 30 days, then weekly for 2 months. 5. The results of these audits/observations will be reported monthly, reviewed and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	

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F0812 SS = E	Continued from page 6 steam table, picked up a tray of food, took the food to resident 28 and placed the dishes of food on the table in front of him. She took the tray back into the kitchenette, put it on a cart of dirty dishes, removed her gloves, put them in the trash can, did not perform hand hygiene, and entered assistant director of nursing (ADON) C's office. At 11:28 a.m. activity director R exited ADON C's office, went into the kitchenette, did not perform hand hygiene, opened a cupboard in the kitchenette and then left the dining room without performing hand hygiene. 2. Interview on 8/13/26 at 8:59 a.m. with activity director R revealed she was a certified nursing assistant (CNA) and had received training on hand hygiene, glove use, and serving residents' meal trays. She would wash her hands and put on a clean pair of gloves to serve the residents' meal trays. If her gloves became dirty, she would remove those gloves, put them in the trash, perform hand hygiene, and put a new pair of gloves on. If a resident was able to pick up their own hamburger bun, she would ask the resident to pick up the bun, and then she would put ketchup on the hamburger for them. If the resident could not pick up their own hamburger bun she would pick it up with her gloved hand and put the ketchup on the resident's hamburger. After she put the ketchup on the bun she would remove her gloves, put those gloves in the trash can, wash her hands and put on a new pair of gloves. She would not wash her hands and put on a clean pair of gloves after she had served a resident's meal, and before she picked up a resident's bun with her gloved hands. 3. Observation on 8/11/26 at 11:07 a.m. of cook O serving the noon meal to residents revealed he had a beard that covered the skin on his face, and was not wearing a beard net. He did not complete hand hygiene and put on a pair of gloves. 4. Observation on 8/11/2026 at 11:12 a.m. of cook O revealed he used his gloved hands to put a hamburger bun on a plate, used tongs to put a hamburger on the bun, held the bun with his gloved hands, and cut the hamburger in half with a knife. He continued placing a bun on each resident's plate with his gloved hand, used tongs to put a hamburger on the bun, and used separate tongs to	F0812		

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F0812 SS = E	Continued from page 7 put lettuce and tomato on the bun. He used his gloved hands to put a slice of cheese on each hamburger. During this meal service, he touched the cupboard and several utensils, including tongs, with his gloved hands. He used the same pair of gloves throughout the meal service. 5. Observation on 8/11/2026 at 11:17 a.m. revealed an unidentified employee in the dining room wearing disposable gloves. The employee touched her nose, did not change her gloves, and then served a resident their meal. She handled the dessert cup by touching the top of the cup with her gloved hand. 6. Observation on 8/11/26 at 11:20 a.m. revealed the same unidentified employee in the above observation, touch her nose again and rub her nostril back and forth three times with her gloved hand. She then served a resident their meal. The employee picked up the resident's juice glass by the top rim of the glass and handed it to the resident. 7. Interview on 8/12/26 at 1:55 p.m. with certified dietary manager (CDM) N regarding the use of disposable gloves when serving meals revealed that utensils should be used if they can be. To serve cheeseburgers, a mixture of gloves and utensils would be used. She indicated the cook should use disposable gloves to put the cheese on the cheeseburger at the point of service, unless they would have time to separate the cheese slices and put them on a plate, then they would use tongs to pick up the cheese slices. CDM N confirmed that hamburger buns and cheese were ready-to-eat foods. She stated that tongs were used to serve dinner rolls, but putting a hamburger bun on a plate would be more difficult. She stated, "Dinner rolls are with a whole plate of food while cheeseburgers take quite a bit of compiling." She would have served the cheeseburger the same way that cook O had, unless she had touched something that was contaminated. CDM N stated the serving area was not always wiped off before serving but always washed afterwards. She confirmed that there was the potential for the serving area to be contaminated if it was not washed off before the meal service. She confirmed staff were to wash their hands before putting on disposable gloves. She agreed if a staff member wore disposable gloves and touched a door, the gloves would potentially be contaminated. CDM N confirmed staff members were to wear hair	F0812		

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F0812 SS = E	Continued from page 8 nets in the kitchen and while serving. She stated "we do have beard nets, and if long enough [the beard] [the staff member] would wear one or if is a problem." She did not think Cook O's beard was long enough to require a beard net. 8. Interview on 8/13/26 at 2:14 p.m. with ADON C and DON B regarding safe food handling, glove use, and staff members wiping their nose when serving residents' meals, revealed DON B stated if a staff member is wiping their nose or touching a resident, they should wash their hands and put on new gloves. She stated, "Glove use in dining and serving [meals] has been a very grey area for years." 9. Review of the provider's contracted dietary 2/2026 Food Preparation Policy revealed that: "All staff will practice hand washing techniques and glove use." and "All staff will use serving utensils appropriately to prevent cross contamination." Review of the provider's 1/2025 contracted dietary Authorized Kitchen Personnel policy revealed: "All authorized personnel must wear appropriate head covering while in the kitchen or production (e.g., hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained)." Review of the provider's 1/2025 contracted dietary Staff Attire policy revealed: "All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained." Review of the provider's 2/27/24 Handwashing/Hand Hygiene policy revealed, "This facility considers hand hygiene the primary means to prevent the spread of infections." "Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ... Before and after direct contact with residents; ... After removing gloves; ... Before and after eating or handling food; Before and after assisting a resident with meals."	F0812		
F0550 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.	F0550		

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F0550 SS = D	Continued from page 9 §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 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: Based on observation, record review, interview, and policy review, the provider failed to ensure that staff protected the residents' right to dignity and privacy for two of three residents (7 and 11) observed with their catheter (flexible tubing placed in the bladder to drain urine) urine collection bags uncovered, with urine visible to others, when the residents were in public areas. Findings include: 1. Observation on 8/11/26 at 10:58 a.m. of resident 7 revealed that he was walking in the hallway, wearing a pair of shorts, and had a catheter urine collection bag with visible urine in it attached to his	F0550	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. The current Catheter Care & Management Policy was reviewed and updated by the DON and CEO on 8/19/26. All nursing home staff were educated and supplied this updated policy on 8/27/26. Any staff not in attendance will receive education and sign acknowledgment by 9/4/26. An order was placed for the facility to receive additional catheter bag covers. Residents that utilize a leg bag will be covered per resident preference and that preference will be documented in the residents care plan. 4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will audit daily for 30 days, then weekly for 2 months. 5. The results of these audits/observations will be reported monthly, reviewed and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	09/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWDLE NURSING HOME	8001 W 5TH STREET POST OFFICE BOX 556, BOWDLE, South Dakota, 57428

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F0550 SS = D	Continued from page 10 leg. There was no cover on the catheter bag. 2. Observation on 8/12/26 at 8:03 a.m. revealed resident 7 was walking out of the dining room. He was wearing shorts, and there was no covering on his catheter urine collection leg bag, and it had urine visible in it. 3. Observation on 8/13/26 at 9:33 a.m. revealed resident 7 and 18 random residents were seated in the dining room for an exercise program. Resident 7 was wearing shorts, his catheter leg bag was not covered, with urine visible in it. 4. Review of resident 7's electronic medical record (EMR) revealed he admitted to the facility on 5/26/26. His care plan indicated staff members were to ensure his catheter bag was "covered for dignity." 5. Observation on 8/12/26 at 7:58 a.m. of resident 11 revealed he was seated at a dining room table in his wheelchair. He had a catheter urine collection bag, with no cover clipped to his wheelchair under the seat of the wheelchair. There was urine visible in the catheter bag. 6. Observation on 8/12/26 at 4:25 p.m. of resident 11 revealed he was seated in his wheelchair. He had a catheter urine collection bag, with no cover clipped to his wheelchair under the seat of the wheelchair. There was urine visible in the catheter bag. 7. Review of resident 11's EMR revealed he admitted to the facility on 10/9/24. His care plan indicated staff members were to ensure his catheter bag was "covered for dignity." 8. Interview on 8/13/26 at 10:37 a.m. with certified nursing assistant (CNA) J revealed that catheter bag covers were not always available for the staff to use to cover residents' urine collection bags, as they were sent to the laundry to be washed every night. In the morning, the staff members would have to wait until the laundry department washed the covers before they could be placed on the residents' catheter urine collection bags. She stated that resident 7 did not want his catheter urine collection leg bag covered, and he did not like to wear long pants that would cover that bag. She stated his care plan did not include his preference for that. She stated that resident 11 should have a cover on his catheter bag. 9. Telephone interview on 8/13/26 at 12:50 p.m. with social service designee (SSD) I, revealed that	F0550		

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F0550 SS = D	Continued from page 11 residents who used a catheter urine collection bag were to have it covered to maintain their dignity. She was aware resident 7 did not have a cover for his catheter leg bag and she was not sure if there was a cover that was made and available for a catheter urine collection leg bag. She indicated the nursing department was responsible for ensuring the catheter urine collection bag coverings were available for the nursing staff to use. 10. Interview on 8/13/26 at 2:09 p.m. with assistant director of nursing (ADON) C and director of nursing (DON) B regarding resident's use of catheter urine collection bag covers revealed that DON B stated those bags were to be covered at all times. ADON C indicated that resident 7 preferred to wear shorts, and she was not aware if a covering for a catheter urine collection leg bag was made, other than the resident wearing long pants. She stated that resident 7 did not want to wear long pants or to cover his catheter leg bag. She expected his preference for wearing shorts and to not have his catheter urine collection leg bag covered to be reflected in his care plan. ADON C stated the catheter bag coverings were to be washed every time the resident's wheelchair was washed, which was done weekly or when soiled. They were not aware that staff washed the catheter urine collection bag coverings each night. 11. Review of the provider's 2001 Catheter Care policy revealed no information regarding covering catheter urine collection bags for the residents' dignity.	F0550		
F0657 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.	F0657		

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F0657 SS = D	Continued from page 12 (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: Based on record review, interview, and policy review, the provider failed to ensure the residents' care plans (a personalized plan that addresses a resident's care needs, goals, and interventions) were reviewed and revised to reflect the current care needs for two of four sampled residents (1 and 17) who received psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) for their symptoms and behaviors. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 6/24/26. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depressive disorder (the persistent feeling of sadness, emptiness, and loss of interest). Her 6/25/26 long term care history and physical report stated she had, "worsening behaviors associated with dementia at home. Her behaviors were almost exclusively towards family members" and "At the beginning of her hospitalization, she expressed comments that were felt to be more out of frustration, but did have an underlying tone of suicidality." She had a 6/24/26 physician's order for sertraline (an antidepressant medication) 100 milligrams (mg) to	F0657	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. The current Care Plan, Comprehensive Person-Centered Policy was reviewed and updated by the DON and CEO on 8/19/26. All nursing home staff were educated and supplied this updated policy on 8/27/26. Any staff not in attendance will receive education and sign acknowledgment by 9/4/26. All care plans of resident's with mood altering medication have been reviewed and updated to reflect current medication, side effects of mediation, target behaviors, and the non-pharmacological interventions that have been utilized. This information has been relayed to all direct care nursing home staff. Moving forward resident care plans will reflect any changes in medication. 4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will monitor and audit each residents care plan weekly to ensure the care is up to date with the correct medication, target behaviors, alternative interventions, and possible side effects. 5. The results of these audits will be reported monthly, reviewed, and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	09/04/2026

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F0657 SS = D	Continued from page 13 be administered daily. Her 8/12/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) did not indicate she was on an antidepressant, what the side effects of that medication were, or what nonpharmacological interventions could be used by a staff member could use to help resident 1 with her symptoms or behaviors. She had an 8/5/26 physician's order for quetiapine (an antipsychotic medication; (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) 50 mg to be administered daily at bedtime to reduce her anxiety and behavioral disturbances. Her 8/12/26 care plan did not indicate she was on an antipsychotic medication, what the side effects of that medication were, or what nonpharmacological interventions could be used by the staff for resident 1's symptoms or behaviors. 2. Review of resident 17's EMR revealed she admitted to the facility on 7/14/26. Her diagnoses included anxiety and depression. She had a 7/16/26 physician's order for duloxetine (an antidepressant) 120 mg to be administered daily. Her 8/12/26 care plan did not indicate she was on an antidepressant, what the side effects of that medication were, or what nonpharmacological interventions could be used by a staff member to help resident 17 with her symptoms. She had a 7/21/26 physician's order for clonazepam (an antianxiety medication) 0.5 mg to be administered daily at bedtime. Her 8/12/26 care plan did not indicate she was on a medication for anxiety, what the side effects of that medication were, or what nonpharmacological interventions could be used by a staff member to help resident 17 with her symptoms. 3. Interview on 8/13/26 at 8:56 a.m. with certified nursing assistant (CNA) K revealed she would know what a resident's behaviors were and what interventions may be effective for helping that resident by referencing that resident's care plan or asking another staff member. 4. Interview on 8/13/26 at 10:54 a.m. with licensed practical nurse (LPN) F revealed that the staff	F0657		

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F0657 SS = D	Continued from page 14 members would be able to see what a resident's behaviors might be on their care plan. Nurses would be able to see what behaviors a resident has had in the past and the interventions that were attempted on the flowsheet in the resident's EMR where any resident behaviors were documented. The interventions on that flow sheet are not individualized, but the individualized nonpharmacological interventions should be on the resident's care plan. 5. Telephone interview on 8/13/26 at 12:54 p.m. with social service designee (SSD) I revealed the nursing department was responsible for documenting a resident's behaviors. She stated director of nursing (DON) B would ensure, that if a resident had suicidal ideation or known behaviors, it was on their care plan. SSD I stated, "We [the residents' facility care team] decide if the resident should be referred to our psychologist; we just monitor behaviors." 6. Interview on 8/13/26 at 2:01 p.m. with DON B and assistant director of nursing (ADON) C revealed they expected that if a resident was receiving medications for a behavior that behavior would be identified on that resident's care plan. A new staff member would not be able to know what a resident's behavior may be or what the nonpharmacological interventions for that behavior were if it was not on that resident's care plan. The "click boxes" on the flowsheet in the resident's EMR were nonpharmacological interventions that were suggested by the EMR as possible interventions for the staff to use and were not personalized to each resident. ADON C expected that all the information related to a resident's mood or behavior be in that resident's care plan along with nonpharmacological interventions for that mood or behavior. She expected resident 1's history of suicidal comments to be identified within her care plan, along with potential interventions for the comments if she should express them later. 7. Review of the provider's 6/2020 Care Plans, Comprehensive Person-Centered policy revealed that: "The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set] assessment (Admission, Annual, or Significant Change in Status), and no more than 21 days after admission."	F0657		

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F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F0732	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. The current Direct Care Staffing Daily Report Posting policy was reviewed and updated by the DON and CEO on 8/19/26. The Direct Care Staffing Daily Report was updated on 8/19/26 to a format that was easier to read and interpret. This new format has been in use since 8/20/26. All nursing home staff were educated and supplied this updated policy on 8/27/26. Any staff not in attendance will receive education and sign acknowledgment by 9/4/26. All staff providing direct care for the day are accounted for and listed on the posting. The report will be updated at each shift by the charge nurse to ensure the scheduled hours have not been altered. 4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will audit daily reports for 30 days, then weekly for two months. 5. The results of these audits will be reported monthly, reviewed, and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	09/04/2026

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F0732 SS = D	Continued from page 16 standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, posted daily nursing staffing review, staff schedule review, and policy review, the provider failed to post the required daily nursing staffing information that clearly reflected actual hours worked by the nursing staff for 5 of 31 days in July of 2026. Findings include: 1. Interview on 8/12/26 at 11:10 a.m. with registered nurse (RN) D revealed she did not know where the daily nursing staffing information was posted. She would know who was working and for how many hours by referring to the staff schedule. She did not change hours worked on any form other than the staff schedule when a staff member did not come to work due to illness. 2. Observation and interview on 8/12/26 at 11:16 a.m. with assistant director of nursing (ADON) C revealed the required daily nursing staffing information was posted on the door jamb of her office at eye level of a standing person. ADON C verified that the 8/12/26 posted daily staffing information indicated there were nursing assistants scheduled and not CNAs. She stated that nursing assistants were not used to cover shifts at the facility. Certified nursing assistants (CNAs) were the staff members used in the facility to care for residents. ADON C acknowledged that the posted daily nursing staffing information indicated there were six nursing assistants scheduled for the 8/12/26 day shift with the total hours for those six nursing assistants documented as 25 hours. ADON C stated that 25 hours was not accurate because there were three CNAs scheduled for eight hours each, one CNA scheduled for 12 hours, and two CNAs scheduled for 5 hours for a total of 46 hours. ADON C acknowledged that she and director of nursing (DON) B provided direct resident care while they were in the facility and their hours were not	F0732		

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F0732 SS = D	Continued from page 17 included on the required posted daily nursing staffing hours. ADON C stated their hours were not included because the night nurse who completed the daily nursing staffing posting would not know if DON B or ADON C were going to be in the facility that day and provide direct resident cares. DON B and ADON C did not update the posted daily staffing to include their direct resident care hours. 3. Review of the provider's July 2026 posted daily nursing staffing forms and staff schedules revealed that on 7/6/26, there were no CNAs identified as working on the posted nursing staffing hours, the hours were posted for nursing assistants. There were three nursing assistants for the day shift on the form for a total of eight hours for those three nursing assistants. The day shift nurse on the daily nursing staffing posting was identified as licensed practical nurse. The staff schedule indicated there were two nurses scheduled for the day shift on 7/6/26, one LPN and one RN. On 7/10/26 there were no CNAs identified as working on the posted nursing staffing hours, the hours were posted for nursing assistants. There were two nursing assistants for the day shift on the form for a total of eight hours for those two nursing assistants. The day shift nurse on the daily nursing staffing posting was identified as a licensed practical nurse. The staff schedule indicated there were two nurses scheduled for the day shift on 7/10/26, one LPN and one RN. On 7/22/26 there were no nurses identified as working for the day or night shifts on the posted daily nursing staffing. On 7/24/26 there was no night nurse identified as working on the posted daily nursing staffing. There were no CNAs identified as working on the posted nursing staffing hours; the hours were posted for nursing assistants. There were three nursing assistants for the day shift on the posted daily nursing staffing form for a total of eight hours for those three nursing assistants. On 7/29/26 there were no CNAs identified as working on the posted nursing staffing hours, the hours were posted for nursing assistants. There were three nursing assistants for the day shift on the posted daily nursing staffing form, for a total of eight hours for those three nursing assistants. 4. Interview on 8/13/26 at 2:01 p.m. with DON B and	F0732		

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F0732 SS = D	Continued from page 18 ADON C revealed that the night shift nurse completed and posted the daily nursing staffing forms each night. If there was a change in the staffing during any shift the charge nurse was responsible for changing the hours or staffing on the posted daily nursing staffing form. DON B and ADON C were aware that the posted daily nursing staffing forms were not being completed accurately according to the staff hours worked. They acknowledged there were times when there were no nurses on the posted daily nursing staffing form. ADON C stated that the provider had a nurse on staff 24 hours per day. 5. Review of the provider's August 2022 Posting Direct Care Daily Staffing Numbers policy revealed, "Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents." "Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs [licensed vocational nurses]) and the number of unlicensed nursing personnel (CNAs and NAs [nursing assistants]) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear readable format." "Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to: assisting with activities of daily living (ADLs), administering medications, supervising care provided by CNAs, and performing nursing assessments." "The information recorded on the form shall include the following: ...Type (RN, LPN, LVN, or CNA) and category (licensed or unlicensed) of nursing staff working during that shift who are paid by the facility (including contract staff); The actual time worked during that shift for each category and type of nursing staff; and Total number of licensed and non-licensed nursing staff working for the posted shift."	F0732		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The	F0755		

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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
F0755 SS = D	Continued from page 19 facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure a medication disposition record was completed for one of one reviewed discharged resident (37). Findings include: 1. Review of resident 37's electronic medical record revealed he discharged from the facility on 4/24/26 to his home with his wife. There was no documentation of the disposition of his medications, which included: metformin, rosuvastatin, losartan, hydrochlorothiazide, citalopram aspirin, amlodipine, and acetaminophen. 2. Interview on 8/13/26 at 1:59 p.m. with director of nursing (DON) B and assistant director of nursing (ADON) C regarding disposition of medications for resident 37 revealed that when he discharged home, they thought his medications were sent home with him and his wife. They were unable to locate any documentation as to what happened to his medications. ADON C stated there was a medication	F0755	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. The current Discharge Medication policy was reviewed and updated by the DON and CEO on 8/19/26. All nursing home staff were educated and supplied this updated policy on 8/27/26. Any staff not in attendance will receive education and sign acknowledgment by 9/4/26.Any resident that is discharged from the facility will have a medication destruction form filled out with the following information listed: resident name, date of discharge, prescription number, order, dose, and any special instructions for each medication. Additionally recorded will be telephone numbers for the pharmacy, physician, facility, the signature of the person receiving the medications, and the nurse releasing medication. 4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will audit all discharged resident's chart weekly. 5. The results of these audits will be reported monthly, reviewed, and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	09/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

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F0755 SS = D	Continued from page 20 disposition form that should have been filled out and included in the medical record, which included the resident's name, prescription number of the medications, and "several other items". DON B and ADON C agreed that not documenting the disposition of medications created the potential for diversion of medications. 3. Review of the provider's 2001 Discharge Medications Policy revealed "The nurse shall complete the medication disposition record, including: a. the resident's name; b. the name of the person who will be assisting or administering the medication after discharge; c. the date of discharge; d. the name and prescription (Rx) number of each medication; f. the strength of each medication; g. any special instructions; h. telephone numbers for the physician, pharmacy, and facility; and i. the signatures of the person receiving the medications and the nurse releasing the medications." "The nursing staff shall forward completed drug disposition records to medical records."	F0755		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F0761		

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F0761 SS = D	Continued from page 21 controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review the provider failed to ensure single dose medications received from the pharmacy had a securely affixed label on the medication bottle for one random resident (14) and that glucometer test strips and medications with shortened expiration dates (medications that, after opening, expire prior to the manufacturer's expiration date) were labeled properly and disposed of after having expired for two random residents (13 and 36) in one of one medication carts. Findings include: 1. Observation and interview on 8/12/26 at 10:43 a.m. of the medication cart with registered nurse (RN) (D) and assistant director of nursing (ADON) C revealed, there was an opened bottle of glucometer test strips in the top drawer of the medication cart. The bottle did not have a date to indicate when it had been opened. RN D verified there was no opened date on the glucometer tests strips. She stated it was their process to date the glucometer test strip bottles when they were opened. She was aware the glucose strips had a shortened expiration date after they were opened but did not know how long it was. In the top middle drawer of the medication cart was a blue pill bottle with a white paper strip wrapped around the bottle that was secured with a rubberband. The white paper strip had handwriting on it that indicated the pill inside the bottle was resident 14's tizanidine (a muscle relaxer). RN D stated she did not know why that bottle was in the top middle drawer of the medication cart or how long it had been in there. RN D checked resident 14's individually bubble packed medication cards and stated that the correct number of remaining	F0761	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. On the day of survey, when surveyor educated DON regarding shortened expiration dates, the DON discarded glucometer strips and re-ordered. The same day the DON re-ordered eye drops and inhaler. Each were discarded per policy upon arrival of new ones from pharmacy in town. The tizanidine was discarded per policy. The current Nova Stat Strip policy, Shortened Expiration of Medication Policy, and Medication Labeling Policy was reviewed and updated by the DON and CEO on 8/19/26. Staff are no longer to use refill date as expiration date or discard date. All nursing home staff were educated and supplied this updated policy on 8/27/26. Any staff not in attendance will receive education and sign acknowledgment by 9/4/26. Local pharmacy was provided with Medication Label Policy on 8/20/2026. Glucometer strips, eye drops, inhalers, and any other medication that has a shortened expiration date will be dated upon opening. A reference list of medications with a shortened expiration date has also been made available to staff that dispense medication. 4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will audit medication cart daily for 30 days and then weekly.	09/04/2026

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F0761 SS = D	Continued from page 22 medications were in each bubble pack. ADON C stated the pharmacy sent single dose medications in the blue bottles. She stated the label should not be wrapped around the bottle with a rubber band but should be secured to the bottle to ensure the label could not be lost, removed, or switched between bottles. Resident 13's bottle of latanoprost eye drops (a medication to lower eye pressure) did not have a date to indicate when the bottle had been opened and administered to resident 13. RN D verified there was no date on the latanoprost eye drops to indicate when it was opened and administered and that latanoprost eye drops were medications that had shortened expiration dates after they were opened. Resident 36's Breo Ellipta inhaler (a medication to treat asthma and chronic obstructive pulmonary disease; a group of lung diseases that block airflow and make it difficult to breathe) did not have a date on it to indicate when the inhaler had been opened and administered to resident 36. RN D verified there was no date on the Breo Ellipta inhaler. RN D stated she was aware that Breo Ellipta inhaler was a medication that had shortened expiration date after it was opened. ADON C stated she was unable to locate a reference of medications that had shortened expiration dates for the nurses to reference to be sure the medications were disposed of at the appropriate time frame according to their outdate after they were opened. 2. Interview on 8/13/26 at 2:01 p.m. with director of nursing (DON) B and ADON C revealed they expected the glucometer test strips and resident medications to be dated when they were opened for administration to the resident. They acknowledged that if they were not dated when they were opened, they would not be able to determine when the medication was outdated. DON B stated there was a note on the medication cart to remind the nurses to date the residents' medications when they were opened. 3. Review of the provider's February 2023 Medication Label and Storage policy revealed there was no information related to medication labels being securely affixed to prescription bottles or medications with shortened expiration dates after opening.	F0761	4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will audit medication cart daily for 30 days and then weekly. 5. The results of these audits will be reported monthly, reviewed, and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	

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F F0761 SS = D	Continued from page 23 4. Review of the provider's 2/4/19 Nova Statstrip Glucose Meter System policy revealed, "StatStrip Test Strips are good for 180 days after opening, or the expiration date printed on the label."	F0761		
F F0880 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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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:	F0880	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. The current Hand Hygiene, Enhanced Barrier Precautions, and Dressing-Dry/Clean Policies were reviewed and updated by the DON and CEO on 8/19/26. All nursing home staff were educated and supplied this updated policy on 8/27/26. Any staff not in attendance will receive education and sign acknowledgment by 9/4/26. Licensed nursing staff will have wound dressing change competencies by 9/4/2026. 4. Corrective actions to be monitored by the DON to ensure the deficient practice will not recur. The DON/designee will enhanced barrier precaution adherence for 30 days and then weekly. 5. The results of these audits will be reported monthly, reviewed, and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	09/04/2026

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F0880 SS = D	Continued from page 24 (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. §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: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were followed by one of one registered nurse (RN) (D) while changing a dressing on a wound for one of one resident (11) who was on enhanced barrier precautions (EBP; glove and gown use when providing contact care). Findings include: 1. Observation and interview on 8/12/26 at 2:13 p.m. of RN D changing the wound dressings on resident 11's legs revealed, there was a sign on his door that indicated he was on EBP and personal protective equipment (PPE (gown and gloves)) hanging on the outside of the door to his room. RN D was in resident 11's room with a gown on. She placed the wound care supplies on resident 11's bedside table without putting a clean barrier on the bedside table. Without performing hand hygiene RN D put on a pair	F0880		

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F0880 SS = D	Continued from page 25 of gloves. She removed resident 11's ace wraps from both his legs on placed them on resident 11's bed. RN D removed her gloves, put them in the trash can and did not perform hand hygiene. RN D exited resident 11's room with her gown on and walked down the hallway. When RN D returned to the room, she had a clean ace wrap in her hand and was wearing a gown and a pair of gloves. She removed the tape and gauze from resident 11's right leg wound, placed the dressing in the trash can, took off her gloves, put the gloves in the trash can, performed hand hygiene, and applied a clean pair of gloves. She used the clean gauze from the bedside table to wipe off the wound on resident 11's right leg. With the same gloved hands, she took the betadine-soaked gauze from the bedside table, placed it on resident 11's right leg wound, covered the betadine-soaked gauze with a dry gauze from the bedside table, and with the tape from the bedside table, taped the gauze to resident 11's right leg. RN D removed her gloves, put them in the trash can, did not perform hand hygiene, and wrapped resident 11's leg with a clean ace wrap without gloves on. RN D performed hand hygiene, put on a new pair of gloves, and removed the dressing from resident 11's left leg wound. With the same gloved hands, she put the betadine-soaked gauze from the bedside table on resident 11's left leg wound and covered the betadine-soaked gauze with a dry gauze from the bedside table. RN D removed her gloves, put them in the trash can, did not perform hand hygiene, and taped the gauze dressing to resident 11's left leg. She then put the ace wrap on resident 11's left leg, and pulled down both pant legs, without wearing gloves. Without wearing gloves, RN D wiped off the bandage scissor with a disinfectant wipe and put it into her shirt pocket. RN D left the room and entered the hallway. While in the hallway she removed her gown, placed it in a trash can, and performed hand hygiene. RN D stated hand hygiene was supposed to be completed before a pair of gloves were put on and after the gloves were taken off. She acknowledged she missed some opportunities for hand hygiene when she removed her gloves. She stated that her gloves were to be changed between the dirty and clean procedures during a dressing change. RN D	F0880		

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F0880 SS = D	Continued from page 26 acknowledged she wore the gown out of resident 11's room and into the hallway to get a clean ace wrap. She acknowledged she put on resident 11's ace wraps, applied tape to the gauze on his right leg, and pulled down his pant legs without wearing gloves and resident 11 was on EBP. 2. Interview on 8/13/26 at 2:01 p.m. with director of nursing (DON) B and assistant director of nursing (ADON) C revealed they expected the staff to perform hand hygiene before putting on gloves and after taking off gloves. They expected staff to wear PPE when assisting a resident on EBP if they were directly working with the residents wound or catheter (flexible tubing placed in the bladder to drain urine). The PPE should be put on when the staff member entered the resident's room and then taken off once the resident's cares had been provided at the threshold of the doorway. When a staff member was preparing to change a resident's dressing on their wound ADON B expected the supplies for changing that dressing to be prepared and placed on a clean barrier within the reach of the nurse who was changing the dressing. She expected the nurse to change her gloves and perform hand hygiene when changing after removing the soiled dressing and before putting on the clean dressing. 3. The infection preventionist was not available for interview during the survey process. 4. Review of the provider's 2/27/24 Handwashing/Hand Hygiene policy revealed, "This facility considers hand hygiene the primary means to prevent the spread of infection." "Use of alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations; ..."Before and after direct contact with residents; ...Before handling clean or soiled dressings, gauze pads, etc.; ...After handling used dressings, contaminated equipment, etc.; ...After removing gloves." "Hand hygiene is the final step after removing and disposing of personal protective equipment [gown and gloves]." 5. Review of the provider's December 2024 Enhanced Barrier Precautions policy revealed,	F0880		

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F0880 SS = D	Continued from page 27 "Gloves and gown are applied prior to performing high contact resident care activity." Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing; ...prolonged, high-contact with items in the resident's room with resident's equipment, or with resident's clothing or skin; ...wound care (any skin opening requiring a dressing)." 6. Review of the provider's undated Dressings, Dry/Clean policy revealed, "Steps in the Procedure Clean bedside stand. Establish a clean field. Place the clean equipment on the clean field...Wash and dry your hands thoroughly. Put on clean gloves. Loosen tape and remove [the] soiled dressing. Pull glove over [the] dressing and discard into plastic or biohazard bag. Wash and dry your hands thoroughly. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. Label tape or dressing with date, time, and initials. Place on clean field. Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze). Wash and dry your hands thoroughly. Put on clean gloves...Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke...Use dry gauze to pat the wound dry. Apply the ordered dressing and secure with tape or bordered dressing per order...Discard disposable items into the designated container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly."	F0880		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/11/26. Bowdle Nursing Home was found not in compliance with the following requirements: E004 and E039.	E0000		
E0004 SS = D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an	E0004	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. The current Emergency Preparedness (EP) Binder was reviewed and updated as needed by the EP team on 8/20/26 during a regular meeting. During that meeting all EP team members were educated regarding the EP binder with all policies and procedures needs be reviewed and updated annually. Any members not in attendance will receive education and sign acknowledgment by 9/4/26. A calendar task has been sent out 8/27/26 to all EP team members as a reminder to review and update the EP Binder by 8/20/27. 4. Corrective actions to be monitored by the CEO to ensure the deficient practice will not recur. The CEO/designee will monitor and audit annually. 5. The results of this audit will be reported to the QAPI committee at the September 2027 meeting.	09/04/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CEO	8/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWDLE NURSING HOME	8001 W 5TH STREET POST OFFICE BOX 556, BOWDLE, South Dakota, 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
E0004 SS = D	Continued from page 1 emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to annually update the Emergency Preparedness binder. Findings include: 1. Record review revealed that the facility's Emergency Preparedness binder located in the administrator's office was not updated annually in 2026. The last annual review was done on 5/16/25. Interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0004		
E0039 SS = D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:	E0039		

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E0039 SS = D	Continued from page 2 (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from	E0039	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. A regular EP meeting was held on 8/20/26g all EP team members were educated regarding the regulations for emergency exercises. Any members not in attendance will receive education and sign acknowledgment by 9/4/26. A live tornado shelter in place scenario was completed on 8/26/26. Information regarding the exercise and after plan were placed in binder on 8/26/26. All meeting minutes and scenario notes will be placed in the EP binder moving forward. 4. Corrective actions to be monitored by the CEO to ensure the deficient practice will not recur. The DON/designee will enhanced barrier precaution adherence for 30 days and then weekly. 5. The results of these audits will be reported quarterly, reviewed, and trended for compliance and further follow up through the facility QAPI committee for a minimum of 3 months and then as needed thereafter.	09/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2026

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E0039 SS = D	Continued from page 3 engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and	E0039		

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E0039 SS = D	Continued from page 4 a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E0039		

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	435107	A. BUILDING B. WING	08/11/2026

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E0039 SS = D	Continued from page 5 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not	E0039		

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E0039 SS = D	Continued from page 6 accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E0039		

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E0039 SS = D	Continued from page 7 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and	E0039		

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	435107	A. BUILDING B. WING	08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0039 SS = D	Continued from page 8 a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the {RNHCI's and OPO's} emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider	E0039		

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E0039 SS = D	Continued from page 9 failed to document two disaster related training event in the Emergency Preparedness binder. Findings include: 1. Record review revealed that the facility's Emergency Preparedness binder located in the administrator's office did not contain two current disaster training events since April 23, 2025 and December 25, 2025. An interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0039		

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	435107	A. BUILDING 01 - MAIN BUILD... B. WING	08/11/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 8/11/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bowdle Nursing Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance.	09/04/2026
K0712 SS = E Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to conduct fire drills as required. Findings include: 1. Record review on 8/11/26 at 9:45 a.m. revealed the provider operated with three shifts. Documentation indicated that fire drills were held on 10/29/25, 12/30/25, 1/29/26, 2/1/26, 3/31/26, 4/19/26, 5/29/26, and 7/27/26. There was a general lack of documentation for the times of the fire drills, no verification that the alarmed drill signals were received by the monitoring agency, or who received the signal at the monitoring agency. Interview with	K0712	2. All residents have the potential to be affected by the practice. 3. The Head of Maintenance was re-educated regarding the fire drill regulation, the fire drill schedule, and the need for proper documentation on 8/19/26. Fire drills will be held monthly with 1 fire drill per shift done quarterly per regulation. Documentation will include all previously included information along with times of fire drills, verification that the alarmed drill signals were received by the monitoring agency, and who received the signal at the monitoring agency. 4. Corrective actions to be monitored by the Head of Maintenance to ensure the deficient practice will not recur. The Head of Maintenance will audit fire drills completion and for adequate documentation monthly. 5. The results of these audits will be reported monthly, reviewed, and trended for compliance and further follow up through the facility QAPI committee for a minimum of 6 months and then as needed thereafter.	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CEO	8/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435107	A. BUILDING 01 - MAIN BUILD... B. WING	08/11/2026

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K0712 SS = E Bldg. 01	Continued from page 1 the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the occupants.	K0712		

South Dakota Department of Health

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	10596	A. BUILDING: _____ B. WING _____	08/13/2026

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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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/11/26 through 8/13/26. Bowdle Nursing Home was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs.	S 206	1. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted August 11, 2026. Please accept this plan of correction as the providers' credible allegation of compliance. 2. All residents have the potential to be affected by the practice. 3. As of 08/19/2026, the responsibility of choosing and assigning education for employees was transitioned from the Director of Human Capitol to the Director of Quality and Compliance. New annual education has been assigned and is due to be completed on 09/04/2026. A cross-walk of the education track and state required education subjects has been obtained to ensure all required areas are covered.	09/04/202

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 9-1-26

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
	10596	A. BUILDING: _____ B. WING _____	08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWDLE NURSING HOME	8001 W 5TH ST POST OFFICE BOX 656 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) COMPLETE DATE
S 206	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on employee review, interview, and policy review, the provider failed to ensure that two of three newly hired employees reviewed (G and H) completed the required orientation training within 30 days of their hire date and three of three employees reviewed (E, L, and M) completed the required annual training. Findings include: 1. Review of contracted travel licensed practical nurse (LPN) G's employee record revealed she was hired on 4/13/26. She did not complete the required orientation training within 30 days of her hire date regarding the topics of mandatory reporting of incidents and diseases, and dining assistance, nutritional risks, and hydration. 2. Review of certified nursing assistant (CNA) H employee record revealed she was hired on 3/1/26. She did not complete the required orientation training within 30 days of her hire date regarding the topic of dining assistance, nutritional risks and hydration. 3. Review of LPN E's employee record revealed she was hired on 8/15/24. She did not complete the required annual training regarding the topics of proper restraint use and advanced directives. 4. Review of CNA L's employee record revealed she was hired on 7/25/23. She did not complete the required annual training regarding the topic of dining assistance, nutritional risk and hydration. 5. Review of restorative aide (RA) M's employee record revealed she was hired on 1/28/22. She	S 206	4. Corrective actions to be monitored by the Director of Quality and Compliance to ensure the deficient practice will not recur. The CEO will audit new hire education completion monthly and annual education yearly. 5. The results of these audits will be reported immediately to Director of Quality/ Compliance and DON for remediation. The results will also be reported monthly, reviewed, and trended for compliance and further follow up through the facility QAPI committee for a minimum of one year and then as needed thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10598	A. BUILDING: _____ B. WING _____	08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWDLE NURSING HOME	8001 W 5TH ST POST OFFICE BOX 556 BOWDLE, SD 57428

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S 206	Continued From page 2 did not complete the required annual training regarding the topics of restraint use. 6. Interview on 8/12/26 at 10:59 a.m. with assistant director of nursing (ADON) C regarding staff education revealed that the business office manager was responsible for assigning and monitoring the staff members' education to ensure it was completed. She indicated that the education that was identified as not being completed may have been included under one of the other topics. She did not have access to the electronic education system to be able to review the syllabus for each assigned training course to determine that. 7. Administrator A was not present during the survey and was not available for an interview.	S 206		