**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLA Identification Number:**

- A. Building: 
- B. Wing: 435107

**Date Survey Completed:** 04/28/2020

**Name of Provider or Supplier:** Bowdle Nursing Home

**Street Address, City, State, Zip Code:**

8001 W 6th Street Post Office Box 556
BOWDLE, SD 57428

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>DATE COMPLETION</th>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
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Surveyor: 29162
A COVID-19 Focused Infection Control Survey was conducted on 4/28/20. The facility was found in compliance with 42 CFR Part 483.80 infection control regulation: F880.

The facility was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(5).

Total residents: 32

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**Laboratory Director's or Provider/Supplier Representative's Signature:**

Darwyn "Kirby" Kieffer, CEO, EPH

5/4/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection of the patients (see instructions). Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a deficiency was cited. 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.