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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435107	A. BUILDING _____ B. WING _____	02/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/5/24 through 2/8/24. Bowdle Nursing Home was found not in compliance with the following requirements: F755, F812, and F880.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set for in the statement of deficiencies. The plan of correction is prepared and/or executed soley because the provisions of federal and state law require it. This plan is submitted to reflect corrective actions taken or to be taken.	
F 755 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(g). The 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	F 755	F755 1. The facility immediately reviewed all narcotics and two nurses verifid that the amounts on hand were correct and accurate. No issues were identified. No residents were found to have been affected. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The Bowdle Nursing Home will continue to ensure a system is established for records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and that drug records are in order and account of all controlled drugs is maintained and periodically reconciled. Narcotics in the locked box were reconciled with the narcotic book and destroyed in the Cactus Smart Sink System (Cactus) by an RN and a second nurse during the time of survey. The discarding and destroying medications policy was revised to reflect that a Registered nurse and second nurse will destroy medications at shift-change the day medications are discontinued. Used Fentanyl Patches will be destroyed by a RN and a LPN or Medication Aid by folding the patch in half with medicine side in and placing in the Cactus, complying with the facility policy. The Cactus container will remain double locked in the medication room. The Director of Nursing will dispose of Cactus containers in accordance with the facility policy. The Director of Nursing will document the destruction of the Cactus container. All licensed nursing staff will be educated, and competency tested by 03/20/2024. This education will be part of the orientation process for all newly hired nurses and medication aides, including agency staffing. 4. To monitor corrective actions and ensure the deficient practice will not recur, the DON/Designee will audit completion of count sheet weekly. This tool will be completed weekly for 8 weeks, then monthly for 2 months. The Quality Council will then advise on frequency of auditing and reporting to the Quality Council. The results will be reported to the Quality Council monthly x 4 months for review and recommendations. Reporting to Quality Council on this matter beyond the 4-month mark will be determined by the Quality Council. 5. All systemic changes will be completed by March 20, 2024.	3/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darwyn "Kirby" Kleffman, CEO		2/28/2024

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

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F 755	Continued From page 1 §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 observation, interview, and policy review the provider failed to ensure they had followed their policy for counting controlled medications in one of one medication storage room waiting for destruction. Findings include: 1. Initial observation on 2/7/24 at 8:56 a.m. of the medication storage room with registered nurse (RN) H revealed: *The controlled medications that were to have been destroyed were kept in a double-locked cabinet. *Medication sheets with the amount of the medication to have been destroyed were kept with the medication until the destruction. *The list of controlled-medications that were due to have been destroyed included the following: -Lorazepam 15 milliliters (mls). -Morphine 14.5 mls. -Clonazepam 0.5 milligram (mg) 27 tablets. -Clonazepam 0.5 mg 7 tablets. -Tramadol 50 mg 13 tablets. Interview with RN H regarding the accountability of the above medications revealed: *Once a controlled medication was discontinued and needed to have been destroyed the process included: -The medication would have been removed from the medication cart and the amount recorded on a form that was kept with the medication. -The medication was then double-locked in the medication storage room for destruction. -The verification of the count of those	F 755		

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F 755	Continued From page 2 medications that were scheduled for destruction were not verified with each nursing shift change. *Nurses had access to the keys to the narcotic cabinet in the medication storage room. Interview with RN H regarding the above observation revealed: *No specific nursing shift was responsible for checking the medication cart for outdated medications. *Nurses were responsible for checking for outdated medication that they were administering. Interview on 2/8/24 at 7:58 a.m. with director of nursing (DON) B regarding the accountability of controlled medications that were scheduled to have been destroyed revealed: *She agreed that the controlled medication had not been counted with each nursing shift change and had not followed their policy. *She had spoken to the pharmacist and discussed the urgency of destroying controlled medications as soon as possible. Review of the provider's June 2002 Controlled Drug policy revealed: *"Narcotics are counted at the change of each shift by the off going and the on-coming nurse and both sign the change of shift count record." -"When controlled keys change hands during a shift, controlled drugs are recounted and both nurses sign the "count record". *"The nurse has two keys: one key for controlled drugs and one for the medication drawers. These two keys must be kept on separate holders."	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 3 §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. §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 provider failed to ensure their food storage policy had been maintained by dating open food packages in one of one kitchens. Findings include: 1. Initial observation on 2/5/24 at 3:50 p.m. of the kitchen storage room revealed: *Two bags of opened graham cracker crumbs bags that were opened not dated. *One bag of taco seasoning mix that was opened and not dated. *Cocoa powder package that was opened and not dated. *Orange gelatin mix package that was opened and not dated. *Vanilla instant pie filling package was opened and not dated.	F 812	F812 1. During the survey, the Dietary Manager went through all the food within the kitchen and nursing home to ensure it had open or use-by dates, and discarded items which were not dated properly. 2. All residents have the potential to be affected by the alleged deficiency. 3. All dietary staff will be educated regarding the food storage policy by 3/6/2024. All nursing home staff will be educated regarding the food storage policy by 3/20/2024. Nursing home staff includes nursing staff, activities staff, and volunteers. 4. The Director of Nursing, Dietary Manager and/or designee will audit the dining room cabinets and fridge one time weekly to ensure open food and/or drinks are dated with opened on date and are not expired. These audits will be documented. 5. The Dietary Manager and/or designee will audit the kitchen refrigerators and food storage areas one time weekly to ensure open food and/or drinks are dated with opened on date and are not expired. These audits will be documented. 6. To monitor corrective actions and ensure deficient practice will not recur, the Dietary Manager will review completion of the audit sheets weekly. These audits (kitchen and dining room) will be completed weekly for 8 weeks, then twice a month for 2 months. The Quality Council will then advise on the frequency of auditing and reporting to the Quality Council. The results will be reported to the Quality Council monthly x 4 months for review and recommendations. Reporting to Quality Council on this matter beyond the 4-month mark will be determined by the Quality Council. 7. All systemic changes will be completed by 3/20/2024.	3/20/2024

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F 812	Continued From page 4 *Cheddar cheese powder sauce mix package was opened and not dated. 2. Observation on 2/5/24 at 4:15 p.m. of the main dining room food storage cupboards revealed: *Cheese puffcorn package that was opened and not dated. -Best use by date on the cheese puffcorn was 9/11/23. *Original puffcorn that was opened and not dated. -Best use by date on the original puffcorn was 10/3/23 *Plain potato chips opened and not dated. - Best used date was 4/2/23 *Rice Crispies cereal opened dated 9/14/23, and another bag of rice crispies that the date was rubbed off. -Rice Crispies, Cheerios, and flake cereal was in plastic containers, these containers were not dated when cereal had been poured into the container. Observation and interview on 2/6/24 at 11:36 a.m. of dietary staff E revealed: *Dietary staff E had removed items from a cupboard in the dining room while serving the resident's lunch. *When a package was opened it should have been dated by the person who opened it. Interview on 2/8/24 8:16 a.m. with dietary staff F revealed: *It is policy to date packages and containers once they are opened. Interview on 2/8/24 at 8:25 a.m. with dietary manager D revealed: *Dietary staff who opened packages were to have dated the packages, and the nursing home staff	F 812		

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F 812	Continued From page 5 was to date when they opened packages in the dining room. *Cereals and other items in the left cupboard in the dining room was dietary's responsibility to manage, twice a week. *Activities personnel overseen the cupboard where chips, puffcorn and other snack items were stored. Review of the providers February 2023 food storage policy revealed: *"Dry Goods Storage areas will be neat, arranged for easy identification, and date marked as appropriate." *"Cold Food Storage policy states all food will be stored wrapped or in covered containers, labeled, and dated, and arranged in a manner to prevent cross contamination."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		

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F 880	Continued From page 6 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	1. Infection control interventions are relevant to all residents and staff in the facility. The resident specifically identified during the survey and listed in the form CMS-2567 were and remain free of symptoms of infections following the completion of the survey process. An in-service is scheduled for 2/29/2024 to provide repeat education to all nursing home staff on hand hygiene, glove use, transitions between "dirty" and "clean" care activities. Competency will also be evaluated. At the same time education will be provided regarding the revised policy for consistent resident identification labeling and changing of oxygen tubing, nasal cannulas, and oxygen humidifier bottles. Education on 2/29/2024 will be provided by Director of Nursing and Infection Preventionist RN. For all facility staff who cannot attend the 2/29/2024 in-service, individual retraining will be completed by DON/designee by 3/20/2024. The Administrator, DON, Infection Preventionist RN, and Medical Director reviewed and revised the oxygen equipment policy on 2/27/2024.	03/20/24

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F 880	Continued From page 7 §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 the following: *Appropriate hand hygiene with glove use for one of one certified nursing assistant (CNA) I with one of one sampled (8) resident while providing personal care. *Changing the oxygen concentrator humidifier bottles for three of three (6, 7, and 21) sampled residents. Findings include: 1. Observation on 2/5/24 at 3:57 p.m. of CNA I while transferring resident 8 with the stand aid mechanical lift from her wheelchair to the bathroom revealed: *Resident 8 was raised to a standing position with the stand aid mechanical lift and transferred to the bathroom. *CNA I applied a pair of gloves without performing hand hygiene and removed the resident's brief. *Removed her gloves and without performing hand hygiene lowered the resident to the toilet. *She then retrieved a clean brief from the resident's closet. *Applied a new pair of gloves without performing hand hygiene and assisted the resident to a raised position and provided personal care. *Removed her gloves and applied a new pair of gloves without performing hand hygiene and secured a clean brief.	F 880	2. All residents and staff have the potential to be affected by the alleged deficiency. Policy education/re-education about roles and responsibilities for the above identified assigned care and service tasks will be provided by Director of Nursing/designee by 3/20/2024. 3. Pocket-sized hand sanitizer will be given to all nursing home staff performing personal cares by 3/24/2024. Wall hand sanitizer stations will be installed in all resident rooms by 4/24/2024 or as available from vendor. A laminated tag with resident initials and oxygen therapy orders will be attached to portable concentrator units. Date labeling of oxygen tubing and humidifer bottles will also be completed with new date identifier stickers. A Teams meeting has been completed with Great Plains Quality Innovation Network Quality Improvemnt Advisor Susan Wilcox, RN on 2/27/2024 involving the Infection Prevention RN and Administrator. Deficient tag F880 was reviewed and use of the fishbone diagram and the 5 why's were discussed and reviewed.	

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F 880	Continued From page 8 *Removed her gloves without performing hand hygiene and assisted the resident to her wheelchair. Interview with CNA I following the above observation regarding glove use and hand hygiene revealed: *She did not have any hand sanitizer in her pockets, but she would use the hand sanitizer on the wall outside of the resident's room. *Hand hygiene training was offered online and hand washing competency was completed in front of a nurse. *She had received her hand hygiene training with her CNA training, but she could not remember any training regarding hand hygiene and glove use. Interview on 2/8/24 at 10:40 a.m. with infection preventionist C and director of nursing (DON) B regarding the above observation revealed: *They both agreed that they do frequent hand hygiene audits. *DON B agreed that CNA I had an opportunity to perform hand hygiene while assisting the resident. Review of the provider's Handwashing/Hand Hygiene policy revealed: *"Perform hand hygiene before applying non-sterile gloves." *After gloves had been removed perform hand hygiene. 2. Review of the provider's "Cleaning of Oxygen Equipment Policy #2021-04" effective 4/2001 revealed: *"D. Oxygen cannula, mask and tubing 1. Change oxygen cannula and mask once a	F 880	After the meeting, a root cause analysis was then conducted and the 5 Whys answered: A. Hand hygiene – Nervous while being watched by surveyor, human error, states she was unaware of policy, and forgot policy. B. Oxygen – Unaware of policy, human error, forgot policy. Administrator, DON, Medical Director, and Infection Preventionist RN will ensure all facility staff responsible for the assigned tasks have received education/training with demonstrated competency and documentation. 4. DON, Infection Preventionist RN and/or designee will perform audits of hand hygiene and glove use. This will be initiated on/before 2/29/2024 and will be completed 6 times per week across two shifts, three times per shift. This will be done for 8 weeks and if compliance is noted, audits will be conducted 2x per month for 2 months. Audit findings will be reported monthly to the Quality Council. Current audits of 27 observations per month will continue thereafter and will be reported monthly at our Infection Prevention Meetings to ensure effective implementation and ongoing sustainment.	

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F 880	Continued From page 9 week. Discard the dirty cannula and mask into the garbage. 3. If humidifier bottle is used, change the oxygen tubing once a week. Discard the dirty tubing into the garbage. E. Humidifier bottle 1. The use of humidifier bottles with oxygen is not recommended as they significantly increase the risk of bacterial contamination of the oxygen equipment. However, if humidifier bottles are used, i.e. for the treatment of nasal dryness: i. Use only sterile distilled water to fill the humidifier bottle. ii. Completely empty the sterile distilled water out of the humidifier once a day, clean with soap and water, rinse well, allow to air dry and then refill the bottle. iii. If the humidifier bottle is disposable, change the bottle once a week. Discard the dirty humidifier bottle." 3. Observation on 2/5/24 at 5:09 p.m. of an oxygen concentrator located in dining room near the entrance door revealed: *The nasal cannula had been dated 1/22 on the green end nearest humidifier bottle. *The plastic zip bag the oxygen tubing and nasal cannula had been dated 1/24. *The clear plastic tube from concentrator to humidifier was labelled "DO NOT REMOVE." *The single use oxygen humidifier bottle had been dated 1/3/24. *The oxygen concentrator and tubing had not been labeled with the resident name. Observation on 2/5/24 at 5:31 p.m. of the same oxygen concentrator in dining room revealed: *Resident 21 was seated at dining room table wearing oxygen connected to the oxygen	F 880	DON and/or Infection Prevention RN will perform audits of compliance regarding labeling of oxygen concentrator, humidifier and oxygen tubing. Audits will be conducted once a week for 8 weeks, then twice per month for 2 months. Audit findings will be reported monthly to the Quality Council for 4 months. Reporting to Quality Council on this matter beyond the 4-month mark will be determined by the Quality Council. 6. All systemic changes will be completed by March 20, 2024.	

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F 880	Continued From page 10 concentrator. Observation on 2/7/24 at 11:00 a.m. of resident 21's oxygen concentrator in the dining room revealed: *The nasal cannula had been dated 2/5 on the green end nearest the humidifier bottle. *The plastic zip bag containing the oxygen tube and nasal cannula had been dated 2/5. *The clear plastic tube from concentrator to humidifier had been labelled "DO NOT REMOVE." *The single use oxygen humidifier bottle had been dated 1/3/24. *The oxygen concentrator and tubing had not been labeled with resident name. Review of resident 21's electronic medical record (EMR) revealed: *He had a physician's order dated 1/29/23 for oxygen (O2) in order to keep O2 level above 90% -- usually 2-4 liters per nasal cannula. *The care plan and doctor order stated oxygen "tube change ordered weekly." -The oxygen humidifier change frequency order stated ".Protocol." *The oxygen humidifier change order had been created 8/16/23 and had been placed on hold 1/8/24 and resumed 1/12/24. *The oxygen humidifier changes had been documented as completed 8/30/23, 9/24/23, 10/17/23, 1/19/24, and 2/5/24, 4. Observation on 2/7/24 at 11:05 a.m. of an oxygen concentrator in dining room located near the food service line revealed: *The nasal cannula had been dated 2/5 on the green end nearest the humidifier bottle.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435107	A. BUILDING _____ B. WING _____	02/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 *The plastic zip bag containing the oxygen tube and nasal cannula had been dated 2/5. *The clear plastic tube from concentrator to humidifier had been labelled "DO NOT REMOVE." *The single use oxygen humidifier bottle had been dated 1/5/24. *The oxygen concentrator and tubing had not been labeled with resident name. Observation and interview on 2/7/24 at 11:13 a.m. with restorative aide G in the dining room revealed: *She had assisted resident 7 to put on the nasal cannula connected to oxygen concentrator. *She had known who the oxygen tubing belonged to, "because she sits there all of the time." Observation on 2/7/24 at 2:03 p.m. in resident 7's room revealed: *The resident was in bed and was wearing oxygen. *The nasal cannula had been dated 2/5 on the green end nearest the humidifier bottle. *The single use oxygen humidifier bottle had not been dated. 5. Observation on 2/7/24 at 1:29 p.m. of the oxygen concentrator located in resident 6's room revealed: *The resident was in bed and was wearing oxygen. *The nasal cannula had been dated 2/5 on the green end nearest the humidifier bottle. *The clear plastic tube from the concentrator to the humidifier bottle had been labelled "DO NOT REMOVE." *The single use oxygen humidifier bottle had been dated 1/3/24.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435107	A. BUILDING _____ B. WING _____	02/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 Review of resident 6's electronic medical record revealed: *Resident 6 had been hospitalized with Covid-19, Sepsis, Respiratory distress, and severe acute respiratory distress on 1/12/23 and returned 1/16/23. *The care plan and doctor order stated oxygen "tube change ordered weekly." -The oxygen humidifier change frequency order stated ".Protocol." *The oxygen humidifier change order had been created 7/23/23 and had been placed on hold 7/28/23 and resumed 7/31/23. *The oxygen humidifier changes had been documented as completed 8/31/23, 9/24/23, 10/12/23, 1/1/24 and 2/5/24. 6. Interview on 2/7/24 at 12:31 p.m. with director of nursing (DON) B regarding her expectations on how staff were to have identified to whom the oxygen concentrators and tubing belonged to revealed: *"The regular staff all know whose concentrators are in the dining room because there are just two" *Oxygen use would have been care planned and communicated by herself to staff. *She stated their policy prohibited the labeling of oxygen concentrators Interview on 2/8/24 at 10:08 a.m. with DON B and phone interview with infection preventionist (IP) C revealed: *There had not been a policy for labeling the concentrator or oxygen tube with the resident information. *They planned to initiate labeling of oxygen tube with resident initials for improved identification. *They were not aware that their policy had stated	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435107	A. BUILDING _____ B. WING _____	02/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 humidifier bottles were to be changed weekly. 7. Review of seating diagram posted in dining room at the front of meal service tray line revealed: *It had been dated 11/30/23. *It indicated that resident 3 was to have been seated at the table nearest the food service line. *It indicated that resident 21 was to have been seated at the table nearest the door.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435107	A. BUILDING _____ B. WING _____	02/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	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 from 2/5/24 through 2/8/24. Bowdle Nursing Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darwyn "Kirby" Kleffman, CEO

TITLE

(X6) DATE: 2/22/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435107	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWDLE NURSING HOME	**8001 W 5TH STREET BOWDLE, SD 57428**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/6/24. Bowdle Nursing Home was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darwyn "Kirby" Kleffman, CEO

TITLE

(X6) DATE: 2/22/2024

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10596	A. BUILDING: _____ B. WING _____	02/08/2024

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

(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 2/5/24 through 2/8/24. Bowdle Nursing Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/5/24 through 2/8/24. Bowdle Nursing Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darwyn "Kirby" Kleffman, CEO

TITLE

(X6) DATE: 2/22/2024