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 _____ | 11/03/2021 |

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

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| F 000 | INITIAL COMMENTS<br><br>Surveyor: 42477<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/1/21 through 11/3/21. Bowdle Nursing Home was found not in compliance with the following requirement(s): F604, F686, F690, and F761. | F 000 | | |
| F 604 SS=E | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive | F 604 | This deficiency has the potential to affect all residents. All residents have the right to be treated with respect and dignity and free from restraints and involuntary seclusion. The Restraint Use policy and procedure was revised and reviewed with all staff. The policy was revised, reviewed, and approved by the CEO, Medical Director, DON, and Director of Quality and Compliance on 11/23/2021. Staff received a copy at the staff meeting held 11/23/2021. All RN/LPN staff were educated on completing the Restraint Assessment in the EMR. Staff members unable to attend the meeting have received a copy of the meeting minutes and policy via email. All staff members read the updated policies and signed they read, understood, and will implement the policy. All residents utilizing a scooped mattress, positioning chair, and/or bed/chair alarms, including sampled Residents 1,10,13,16 had a restraint assessment completed on 11/23/21. Any resident that will utilize any device that is considered to be a restraint per F604, will be care planned and have the Restraint Assessment completed in the EMR prior to utilizing device to determine medical necessity, and evaluated to be the least restrictive, with a time frame for use to be the least amount of time utilized; this will be ordered by the provider. Residents that utilize devices will be reevaluated for use monthly at a minimum and reviewed at care conference by IDT, family, and resident. This will be done by the charge nurse weekly. The Falls Committee will monitor this weekly for the next six months or as deemed necessary by Quality Council.The DON will report to Quality | 11/23/2021 |

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

Darwyn "Kirby" Kleffman | CEO/Administrator | 11/23/2021

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 604 | Continued From page 1<br>alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 29354<br>Based on observation, interview, record review, and policy review, the provider failed to ensure four of four sampled residents (1, 10, 13, and 16) had been assessed for the use of a scooped mattress, positioning chairs, and chair and/or bed alarms as restraints or enablers. Findings include:<br><br>1. Observation of resident 13 on the following dates and times revealed on:<br>*11/1/21 at 5:00 p.m. she had been sitting reclined in a Geri-chair in the lounge area.<br>*11/2/21 at 9:30 a.m. and at 11:00 a.m. she had been sitting in a reclined Geri-chair in her room.<br><br>Review of resident 13's medical record revealed:<br>*Diagnoses of Down syndrome, dementia, muscle weakness, osteoarthritis, and history of falls.<br>*The 9/13/21 quarterly Minimum Data Set (MDS) assessment had been documented she required:<br>-Total assistance of two staff with transfers and toilet use.<br>-Extensive assistance of two staff with dressing and personal hygiene.<br>*She had used a sit-to-stand lift for transfers.<br>*On 8/26/21 she had an incident where she had started to slip out of the sit-to-stand lift and they had changed her to a total mechanical lift.<br>*There was not an evaluation/assessment for the use of a Geri-chair.<br>*The Geri-chair had not been listed on her care plan. | F 604 | Council on a quarterly basis until the committee recommends discontinuing. | |

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| F 604 | Continued From page 2<br><br>Interview on 11/3/21 at 10:00 a.m. with registered nurse/minimum data set (RN/MDS) coordinator D regarding resident 13 and the Geri-chair revealed:<br>*She used the Geri-chair for repositioning.<br>*It had helped decrease her falls.<br>*She had been found to be unsafe in a wheelchair.<br>*She felt resident 13 would be able to get out of the Geri-chair if she wanted to.<br>*They had not done an assessment for resident 13 to use the Geri-chair.<br>*She confirmed there was no documentation:<br>-They had done an assessment for her to use the Geri-chair.<br>-She could get out of the Geri-chair by herself.<br><br>Interview on 11/3/21 at 12:17 p.m. with DON C regarding resident 13 and the Geri-chair revealed:<br>*The Geri-chair had not been listed on the care plan.<br>*Resident 13 began using the Geri-chair on 8/26/21.<br>*They had not done an assessment for her to use the Geri-chair.<br>Surveyor: 42477<br>2. Observation on 11/1/21 at 5:00 p.m. of resident 10 revealed she:<br>*Was sitting in her wheelchair, in the doorway of her room.<br>*Had a chair alarm on her wheelchair.<br>*Was very confused and worried she was going to miss supper.<br><br>3. Observation on 11/1/21 at 5:22 p.m. of the facility's main dining room revealed:<br>*Residents 1, 10, and 16 were eating supper. | F 604 | | |

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| F 604 | Continued From page 3<br>*Resident 1 was in a Geri-chair.<br>*Resident 10 and 16 both had alarms on their wheelchairs.<br><br>Observation on 11/1/21 at 6:00 p.m. of resident 16's room revealed he had a scooped mattress.<br><br>Review of the provider's 11/2/21 Resident Census and Conditions of Residents form filled out by the provider revealed they did not have any residents who had restraints.<br><br>4. Observation and interview on 11/2/21 at 10:00 a.m. with resident 1 revealed:<br>*He was reclined back in a Geri-chair.<br>*An unidentified staff member came in his room to get a lift that was positioned behind his Geri-chair.<br>*He asked the staff member:<br>-"Are you going to sit me up now?"<br>*The staff member had not answered his question and took the lift and left the room.<br><br>Interview on 11/3/21 at 9:37 a.m. with director of nursing (DON) C revealed:<br>*They have no residents that had restraints.<br>*She had not felt that alarms, chairs, or mattresses could be considered restraints.<br>*They did not have assessments for the devices.<br>*She did not feel that alarms could be restraints because they were used to alert staff when the resident moved.<br>*She agreed resident 1 would be unable to reposition himself in a reclined Geri-chair.<br><br>Review of resident 16's record revealed:<br>*He had a bed, chair alarm and scooped mattress as of 12/2/20.<br>*He had seven falls after the implementation of | F 604 | | |

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| F 604 | Continued From page 4<br>those devices.<br><br>Review of resident 10's medical record revealed:<br>*She had devices removed 2/20/19.<br>*Staff were unsure of when the devices were implemented again.<br>*She had continued to have falls.<br><br>Interview on 11/3/21 at 11:45 a.m. with DON C, physician assistant (PA) G and the director of quality and compliance B revealed:<br>*They have a fall committee that meets every week.<br>*They did not have any documentation of the fall committees' discussions or recommendations.<br>*They felt that falls had improved since implementing the devices.<br>*Nursing decides who had a device or alarm placed.<br>*They had not tracked or monitored if the devices were effective or if they were restraints.<br><br>Review of the provider's September 2017 Restraint Use Policy and Procedure revealed:<br>*"It is the philosophy of [facility's name] to keep residents unrestrained and as independent as possible. If the results of a comprehensive, interdisciplinary assessment determine that there are no alternative[s] to provide resident safety, or that the alternative methods have been unsuccessful, a physical and/or chemical restraint will be recommended for use..."<br>*"Physical restraint: any manual or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body..." | F 604 | | |

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| F 686 | Continued From page 5 | F 686 | | |
| F 686 SS=E | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on observation, interview, record review, and policy review, the provider failed to ensure assessments had been completed related to monitoring and preventing skin issues for five of twelve sampled residents (1, 5, 10, 16, and 27). Findings include:<br><br>1. Interview with resident 5 on 11/2/21 at 8:45 a.m. revealed she:<br>*Was sitting in a recliner.<br>*Had a bed in her room that contained many of her items.<br>*Stated she preferred to sleep in her recliner.<br>*Had an open area to her bottom.<br>*Stated it had been there for a little while.<br>*Stated staff were aware of the area.<br><br>Surveyor 45383:<br>Observation and interview on 11/2/21 at 1:00 p.m. | F 686 | This deficiency has the potential to affect all residents. All residents have the right to receive quality of care to attain/maintain the highest practicable level to prevent pressure ulcers unless a resident's clinical condition demonstrated that they were unavoidable. Any resident that does endure altered skin integrity, has the right to receive necessary treatment and services to promote healing, prevent infections and new alterations from developing. The Prevention and Assessment of Pressure Ulcers policy was revised and all staff received education on the revised policy on 11/23/2021. The policy was revised, reviewed, and approved by the CEO, Medical Director, DON, and Director of Quality and Compliance on 11/23/2021. RN/LPN staff were educated to document skin assessments under the Skin Basic intervention in the EMR. Staff received a copy of the policy at the staff meeting held on 11/23/2021. Staff members unable to attend the meeting have received a copy of the meeting minutes and policy via email. All staff members read the updated policies and signed they read, understood, and will implement the policy. All residents, including Residents 1,5,10,16, and 27, with a BRADEN score of 12 or below or with altered skin integrity currenly will have a head to toe assessment done at a minimum of weekly. Any new admission will have a head to toe skin assessment completed within 24 hours of admission by a RN. Any resident that endures altered skin integrity or a BRADEN score of 12 or below will have a skin assessment done weekly by the charge nurse or more frequently with change in condition. Those that have a BRADEN score of 13 or more | 11/23/2021 |

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| F 686 | Continued From page 6<br>with registered nurse(RN)/minimum data set (MDS) coordinator D and certified nursing assistant (CNA) F revealed:<br>*Resident 5 had two open areas to her bilateral posterior upper thighs.<br>*The two areas appeared to be 2 centimeters (cm) by 0.5 cm.<br>*Resident 5 also had two dark purple macerated areas in her bilateral buttocks area.<br>-Those two round dark purple areas appeared to ready to open.<br><br>Surveyor 42477:<br>Interview on 11/2/21 at 1:15 p.m. with CNA F revealed:<br>*Resident 5 did have open areas on the back of her thighs.<br>*She had noticed the open areas that morning.<br>*She had informed RN/MDS coordinator D about the areas.<br><br>Interview on 11/2/21 at 2:00 p.m. with RN/MDS coordinator D regarding resident 5's wounds revealed:<br>*She had been aware of the one open spot on one posterior upper thigh.<br>*They had been putting Cavlion spray on the wound.<br>*CNAs let licensed nurses know during resident's baths if they have any skin issues.<br>*Surveyor asked if they do routine skin assessments on residents who are at risk for skin breakdown or have had skin issues:<br>-RN/ MDS coordinator D stated they did not.<br><br>Review of resident 5's Braden assessments revealed:<br>*On 5/27/21 she was determined to be at moderate risk for skin breakdown. | F 686 | with minimal skin breakdown risk will have a skin assessment done with each MDS/ provider recertification at a minimum. BRADEN skin assessments are done with each resident upon admission and with each MDS. If there is noted to be altered skin integrity, the RN will assess, evaluate, address, and notify the provider/family/ POA. The DON will monitor skin assessments for compliance weekly and report results to the Quality Council monthly until the committee recommends discontinuing. | |

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| F 686 | Continued From page 7<br>*On 8/25/21 she was determined to be at mild risk for skin breakdown.<br><br>Review of resident 5's skin assessments revealed:<br>*On 5/27/21 she had been admitted to the facility.<br>*On 6/3/21, her first skin assessment was completed and revealed:<br>-On Left buttocks, "skin original was purplish red on admission here at [nursing home name] had prior open area from previous hospital admission."<br>-The area on the left buttocks was marked as "open."<br>-She also had an open area to her left upper posterior thigh.<br>-The right upper posterior was noted to have a similar area to the left but they "will monitor."<br>-They noted they would use Cavilon spray for the areas.<br>*On 6/7/21:<br>-There was no documentation if the area on the left buttock was open or closed.<br>-Upper left thigh was open.<br>-The note about the right upper posterior was the same as the above 6/3/21 skin assessment.<br>-Continue to use Cavilon spray daily.<br>*On 6/14/21:<br>-Now the right upper posterior thigh was marked as open.<br>-There was the same note about the right upper thigh like the left thigh but not open.<br>-Just below that was noted the wound was open.<br>*On 6/21/21:<br>-Buttocks was healed.<br>-There were open areas to her left and right upper posterior thigh.<br>-There was still a note stating it was open and "will monitor." | F 686 | | |

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*The skin assessments noted open and closing wounds.
*The treatment had always been marked as Cavilon spray or open to air.
*From 6/3/21 through 11/2/21 she had areas on her left and right upper posterior thighs and buttocks that were open.
*There were inconsistencies in frequency of documentation.

Review of resident 16's skin assessments revealed:
*He had two skin assessments completed for 2021.
*One was completed in January 2021.
*The other skin assessment was completed October 2021, after he had a skin tear.

Review of resident 1's skin assessments revealed:
*His admission skin assessment on 3/10/21 stated:
-"wife states coccyx was open but not at this time, has very fragle [fragile] skin, gets pink when on buttock for to [too] long of period, does have gel cushion in wh/ch [wheelchair]..."
*The next skin assessment was completed about three months later on 6/11/21.
*The 6/11/21 assessment stated:
-He had a 5.0 centimeters (cm's) by 2.0 cm red area.
-Although he had been noted to have fragile skin and red areas his skin assessments had gaps in documentation.
-Some assessments were completed weekly, others had more than a month of missing assessments.

Review of resident 1's two most recent Braden

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assessments revealed he was at high risk for skin breakdown.

Review of resident 27's skin assessments revealed:
*He had no issues on his admission skin assessment completed on 4/20/21.
*On 4/23/21 he:
-Had a blister to his left heel.
-3.5 cm by 3.5 cm.
-They would treat it with Betadine two times per day and heel protectors.
*On 4/28/21 he:
-Had the same note as the 4/23/21 note.
*On 5/3/21 he:
-Had the same blisters on his left heel.
-The area was noted to have very little fluid left in the blister.
-Had a blister that was intact.
-Would receive twice a day Betadine treatments to his heel as well as heel protectors.
*On 5/10/21 he still had an intact blister on his left heel.
*On 5/17/21 the blister was assessed to be healed.
*He had not had any skin assessments completed from 5/17/21 through 11/2/21.

Review of resident 10's skin assessments revealed she had one skin assessment completed for the year of 2021.

Interview on 11/3/21 at 9:37 a.m. with the director of nursing (DON) C revealed;
*She considers the Braden assessments as their skin assessments.
*Nurses only complete skin assessments after they had been notified of a skin issue.

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| F 686 | Continued From page 10<br>Interview on 11/3/21 at 11:26 with physicians assistant (PA) G revealed he:<br>*Was a provider for the facility.<br>*Was not aware that nurses would not do skin assessments unless there had been an issue.<br>*Not aware of the skin issues that resident 5 had.<br><br>Review of the provider's 11/2/21 Resident Census and Conditions of Residents form filled out by the provider revealed:<br>*They had one resident with a pressure ulcer, resident 22.<br>-That resident was not resident 1, 5, 10, 16, or 27.<br>*They did not have any residents who had rashes.<br>*They did not have any residents receiving preventive skin care.<br><br>Review of the provider's May 2019 Prevention and Assessment of Pressure Ulcers policy revealed:<br>*"The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors."<br>*"The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed."<br>*"Charge nurse will assess resident's skin for every MDS assessment and as indicated and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown."<br>*"The care process should include efforts to stabilize, reduce or removed underlying risk factors; to monitor the impact of the interventions; | F 686 | | |

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|---|---|---|---|
| | 435107 | A. BUILDING _____ B. WING _____ | 11/03/2021 |

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

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| F 686 | Continued From page 11<br>and to modify the interventions as appropriate." | F 686 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. | F 690 | This deficiency has the potential to affect all residents. All residents have the right to receive services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. The Urinary Catheterization policy was revised and all staff received education on the revised policy on 11/23/2021. The policy was revised, reviewed, and approved by the CEO, Medical Director, DON, and Director of Quality and Compliance on 11/23/2021. Staff members unable to attend the meeting received a copy of the meeting minutes and the policy via email. All staff members read the updated policies and signed they read, understood, and will implement the policy. Resident 8's catheter was deemed no longer medically necessary and was removed on 11/11/2021. All residents with an indwelling device in BNH were deemed medically necessary with documentation in place by provider. For all future residents in medical need of a foley catheter, providers will assess, document, and order the resident(s) for continued medical necessity. Assessments and documentation by providers will be done prior to insertion, on a continuous basis with re-certification rounds, and as needed. Provider communication tool used by all providers during a resident(s) appointment, were updated on 11/10/21 and are currently being used.The DON will monitor provider documentation on current indwelling devices on quarterly, provider recertification, appointments and upon insertion of any new indwelling device. The DON will report monitoring of results at Quality Council on a quarterly basis until the committee deems discontinuing. | 11/23/2021 |

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| | 435107 | A. BUILDING _____ B. WING _____ | 11/03/2021 |

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| F 690 | Continued From page 12<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 45383<br>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (8) who had an indwelling Foley catheter had been reassessed for its continued use. Findings include:<br><br>1. Observation and interview on 11/1/21 at 4:35 p.m. with resident 8 revealed:<br>*She was in her room seated in a wheelchair.<br>*There was a Foley catheter bag hanging from the right armrest of her wheelchair.<br>-Above the resident's bladder level for proper drainage.<br>*She stated she had fallen on 8/23/21 at her residence while on trial leave from the nursing home and had the catheter ever since.<br>*Had fractured her right femur.<br>-The fracture was inoperable.<br>*Had been admitted for observation to the hospital on 8/24/21.<br>*The Foley catheter was placed at that time.<br>*Was readmitted to the nursing home on 8/25/21 with Foley catheter in place.<br><br>Review of resident 8 physician order updated 8/25/21 revealed there had been no order for the Foley catheter.<br><br>On 11/3/21 at 11:00 a.m. interview with director of nursing (DON) C regarding resident 8's Foley catheter revealed:<br>*She stated that physical therapy was managing the need for the Foley catheter.<br>*She also stated that physician assistant (PA) G was also managing the need for the Foley catheter. | F 690 | | |

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| F 690 | Continued From page 13<br><br>Interview on 11/3/21 at 11:00 a.m. with (PA) G regarding the medical necessity for resident 8's Foley catheter revealed:<br>*Resident 8 had been incontinent of urine and feces upon admission to the emergency department (ED) on 8/24/21.<br>*Resident 8 was non-weight bearing to right leg for 6-8 weeks<br>*He had been aware of her history of urinary tract infection (UTI) when catheter was placed.<br>-Resident 8 had UTIs in the past related to her incontinence.<br>*He stated that due to resident's immobility and convenience the catheter was still in place.<br>*He had been aware that her activity was increased to 50% weight bearing to her right leg on 10/25/21.<br>*Provider was unable to provide documentation for order and rational for Foley catheter.<br><br>Review of resident 8's 10/12/21 dated progress notes revealed:<br>*Blood was noted in resident 8 Foley catheter.<br>*There was an order for urinalysis on 10/12/21 to be collected with Foley catheter change.<br>*Her urinalysis was positive for a urinary tract infection.<br>-No urine culture was ordered.<br>-Order for Ciprofloxacin 500 milligrams orally twice a day for seven days.<br><br>Review of resident 8's 10/25/21 dated progress notes revealed:<br>*There had been an x-ray of her right femur that showed some healing through the fracture site.<br>*She had an increase in her activity to 50% weight bearing to right leg.<br>*The need for Foley catheter was not addressed | F 690 | | |

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| F 690 | Continued From page 14<br>with increase in mobility.<br><br>Review of resident 8's 8/25/21 care plan revealed:<br>*Staff were to:<br>- Provide catheter care/incontinence care<br>-Clean perineal area with each incontinent episode<br>*She had a history of recurrent UTIs.<br><br>Review of provider's 7/7/21 Urinary Catheterizations policy revealed:<br>*Purpose of urinary catheterization is to facilitate urinary drainage when medically necessary.<br>-Urinary catheters should be evaluated every day for the need and removed promptly when no longer necessary.<br>-The purpose of this procedure is to prevent catheter-associated urinary tract infections.<br>*Urinary catheters should be inserted only when medically necessary. Urinary catheters should not be solely for the convenience of health care workers.<br>-Urinary catheters should be placed under the direction of provider order. | F 690 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals | F 761 | This deficiency has the potential to affect all residents. It is the responsibility of the facility to ensure that all drugs and biologicals used are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions. The Hazardous Medication Administration policy was created and all RN/LPN's received education on the policy on 11/23/2021. The policy was created, reviewed, and approved by the Pharmacist, CEO, Medical Director, DON, and Director of Quality and Compliance on 11/23/2021. Staff members unable to attend the meeting received a copy of the meeting | 11/23/2021 |

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| | 435107 | A. BUILDING _____ B. WING _____ | 11/03/2021 |

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| F 761 | Continued From page 15<br>§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 controls, and permit only authorized personnel to have access to the keys.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 45383<br>Based on observation, interview, record review, and policy review, the provider failed to ensure safety for handling and preparing cytotoxic (means they can present significant risks to those who handle them as well as the intended use of altering cells by damage or death, when treating a patient/resident) medication. Findings include:<br><br>1. Observation and interview on 11/2/21 at 8:00 a.m. with registered nurse (RN) E during medication administration revealed:<br>*Resident 1 had an order for Finasteride 5 milligrams orally daily.<br>-Medication had been crushed for administration.<br>*The medication is a cytotoxic medication with black box warning risk.<br>*There was no warning of cytotoxicity warning on the medication administration record (MAR).<br>*RN E was aware that medication was a cytotoxic medication.<br>-She had not worn gloves while handling and | F 761 | minutes and the policy via email. All staff members read the updated policies and signed they read, understood, and will implement the policy. On 11/18/2021, the Pharmacist assessed all hazardous /cytotoxic medications administered. Starting on 11/18/2021, all cassettes containing a hazardous medication are marked by an appropriate sticker from the Pharmacy. In addition, as of 11/4/2021, the Pharmacist verified all hazardous/cytotoxic medications have appropriate labels in the MAR. On 11/19/2021, the resident's cytotoxic medication being crushed was discontinued. As of 11/23/2021, the Pharmacist had created an Assessment of Risk Binder for all hazardous/cytotoxic medications administered in the nursing home to ensure all staff have an additional reference on the cytotoxic precautions necessary for the hazardous/cytotoxic medications administered. On 11/22/2021, the monthly pharmacist drug review sheet was updated to assist with monitoring of hazardous/cytotoxic medications. The Pharmacist will monitor all current and new hazardous/cytotoxic MAR labels for appropriateness and all cassettes for appropriate sticker on a monthly basis. The Pharmacist will report his findings at Quality Council on a monthly basis until the committee deems discontinuing. | |

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| F 761 | Continued From page 16 | F 761 | | |

preparing the medication.
-She had not noticed that it had not been flagged for cytotoxicity on MAR.

Interview on 11/3/21 at 11:20 a.m. with pharmacist H regarding labeling medication revealed:
*He was surprised to learn there was instruction to dissolve medication in water was on the medication MAR.
-Medication is crushed for administration for resident 1.
*He was aware the medication was cytotoxic.
*He was going to change the information on the MAR to warn of cytotoxicity.

Review of the provider's 6/29/21 signed pharmacist consultant agreement revealed.
*The pharmacist consultant should:
-Ensure prescriptions were properly procured and maintained.
-Ensure narcotics and dangerous and legend drugs had been properly accounted for.

Interview on 11/3/21 at 1:00 p.m. with director of nursing C regarding education of medication safety revealed:
*She had not performed any education with nursing staff on properly handling cytotoxic medication.
*She hoped nursing staff were aware of side effects of medication they had prepared and administered.
*Stated staff were to drug reference book for reference if unsure of medication.
*She had not been aware the medication had not be flagged for cytotoxicity on MAR.
*She stated, since the interview with pharmacist H he had added the warning to updated MAR.

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| F 761 | Continued From page 17<br>*She agreed the pharmacist had not labeled medication cassette with warning of cytotoxicity.<br>*The medication had been administered without warning since 3/19/21.<br><br>Review of provider's 7/7/17 Medication Administration policy revealed:<br>*The director of nursing will supervise and direct all nursing personnel who administer medication or have a related function.<br>*The individual administering the medication must verify the right medication, right dosage, right time and right method of administration before giving the medication. | F 761 | | |

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

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| | 435107 | A. BUILDING _____ B. WING _____ | 11/03/2021 |

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| E 000 | Initial Comments<br><br>Surveyor: 42477<br>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 11/1/21 through 11/3/21. Bowdle Nursing Home was found in compliance. | E 000 | | |

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

Darwyn "Kirby" Kleffman | CEO/Administrator | 11/23/2021

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
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| | 435107 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **11/02/2021** |

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

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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 18087<br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/2/21. Bowdle Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222 and K911 in conjunction with the providers commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 222 SS=F | Egress Doors<br>CFR(s): NFPA 101<br><br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the | K 222 | This deficiency has the potential to affect all residents. Upon further investigation by the Maintenance Director, Director of Quality and Compliance, and the DON, it was found that the A Wing and B Wing doors open without restriction under the facility lockdown function and while the facility is on scheduled lock down from 9:00pm to 6:00am. To remedy the patio door, the Maintenance Director removed the magnetic lock on 11/18/2021. Communication with Burdette Security on 11/18/2021 confirmed delayed egress equipment for A Wing, B Wing, and Patio doors is scheduled to arrive in the next few weeks. The Maintenance Director will remain in communication with Burdette Security and will oversee completion of the installation of the delayed egress equipment. The Maintenance Director will report weekly to the CEO and Director, Quality and Compliance on updates of the installation. Upon installation of the delayed egress equipment to the three doors, the Maintenance Director will report to the Quality Council quarterly until the committee recommends discontinuing. | 11/18/2021 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Darwyn "Kirby" Kleffman | CEO/Administrator | 11/23/2021 |

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| | 435107 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/02/2021** |

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| K 222 | Continued From page 1<br>Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by: | K 222 | | |

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| | 435107 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/02/2021** |

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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 |
|---|---|---|---|---|
| K 222 | Continued From page 2<br>Surveyor: 18087<br>Based on observation, testing, and interview, the provider failed to provide egress doors as required at three of five locations (A wing, B wing, and Patio). Findings include:<br><br>1. Observation on 11/2/21 beginning at 2:00 p.m. revealed the A wing exterior exit door was equipped with a magnetic lock at the top of the door. There were no signs stating if the magnetic lock was a delayed egress door. Testing of the door revealed it was not locked, but was alarmed. Interview with the maintenance supervisor at the time of the observation revealed the doors were automatically locked at 9:00 p.m. each night and automatically released at 6:00 a.m. each day. He also stated a Wanderguard magnetic locking system was planned for installation at that door. Further interview revealed the B wing and Patio exit doors were similarly equipped.<br><br>Failure to provide egress doors as required increases the risk of death or injury due to fire.<br><br>The deficiency affected three of five exit doors.<br><br>Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a) | K 222 | | |
| K 911 SS=D | Electrical Systems - Other<br>CFR(s): NFPA 101<br><br>Electrical Systems - Other<br>List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. | K 911 | This deficiency has the potential to affect all residents. On 11/3/2021, the Maintenance Director communicated with G&R Construction's General Contractor, Paul Doohen, regarding the impingement around the panel boards and switches due to his team's supplies. Communication was sent from Paul to his crew on 11/3/2021. Overseen by the Maintenance Director, all materials impinging the working space around the panel boards and switches was removed. Following the completion | 11/3/2021 |

| 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<br>B. WING _____ | 11/02/2021 |

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

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|---|---|---|---|---|
| K 911 | Continued From page 3<br>Chapter 6 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 18087<br>Based on observation and interview, the provider failed to maintain the required clearance for electrical equipment in the generator electrical room. Findings include:<br><br>1. Observation on 11/2/21 at 2:30 p.m. revealed numerous boxes of wiring supplies such as Cat 5 cables were kept in the electrical room for the nursing home generator. The boxes were sufficient in number to impinge on the required depth of working space clearance for the panel boards and switches in the room.<br><br>Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated contractors working on renovations in the hospital were using the generator electrical room to stage and store their supplies.<br><br>The deficiency affected one of numerous requirements for the maintenance of electrical equipment. | K 911 | of current construction project, the Maintenance Director will be placing a perimeter paint on the floor to ensure sufficient required depth of working space clearance of electrical boards and switches. During the continued construction project, the Maintenance Director will monitor sufficient working space clearance on a weekly basis and report to Quality Council on a monthly basis until the committee recommends discontinuing. | |

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 _____ | 11/03/2021 |

| 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<br><br>Surveyor: 42477<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/1/21 through 11/3/21. Bowdle Nursing Home was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 42477<br>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 11/1/21 through 11/3/21. Bowdle Nursing Home was found in compliance. | S 000 | | |

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

Darwyn "Kirby" Kleffman

TITLE

CEO/Administrator

(X6) DATE

11/23/2021