STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOW RUMMEL VILLAGE	**1321 W DOW RUMMEL ST , SIOUX FALLS, South Dakota, 57104**

(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 An onsite revisit survey was conducted from 7/14/26 through 7/15/26 for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities for all previous deficiencies cited on 6/10/26. Dow Rummel Village was found not in compliance with the following requirement: F689.	F0000	Resident 2's fall risk assessment, care plan, pocket care plan, and resident-specific fall interventions were reviewed and updated as needed. Resident 2 was verified to be on the Falling Leaf program. The Falling Leaf identifier was placed on the resident's wheelchair. The doorframe Falling Leaf magnet was also verified to be in place. Facility nursing staff who worked on or after 07/10/26 and had not completed the required F689 education and competency were identified. Education and competency validation were completed for identified facility nursing staff who have worked since the revisit. Any identified facility nursing staff who have not returned to work will complete the required education and competency validation prior to working their next scheduled shift. All residents have the potential to be affected by the same deficient practice. The DON/designee reviewed residents with a history of falls, residents identified at increased risk for falls, and residents on the Falling Leaf program. The review included verification of current fall risk assessments, resident-specific fall interventions, care plan accuracy, pocket care plan accuracy, and implementation of identified interventions.	08/01/2026
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on review of the provider's accepted plan of correction (POC) with a completion date of 7/10/26 for the 6/10/26 complaint survey, interview, observation, and record review, the provider failed to ensure the POC was followed related to staff education, training, and policy implementation. Findings include: 1. Review of the provider's accepted POC with a completion date of 7/10/26 revealed that the "Directed in-service training will be completed by 07/10/26 for nursing staff regarding resident safety, fall prevention, supervision, safe bed height, change-of-shift walking rounds, visual safety checks based on the resident's plan of care, the Falling Leaf program, resident-specific hourly safety checks when indicated, placement of tent lights and call lights, and documentation of new fall interventions. Staff competency will be validated through verbal review and/or return demonstration."	F0689		

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
Christopher Hahn	Administrator of Health Care Services	07/30/2026

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F0689 SS = E	Continued from page 1 2. Interview on 7/14/26 at 2:00 p.m. with certified nursing assistant (CNA) I revealed that there she received recent education about fall risks, but she was not aware of what the “Falling Leaf Program” was. 3. Review of the POC documentation and staff schedules revealed that the following nursing staff members who worked on 7/10/26 did not receive the education or competencies described in the POC: licensed practical nurse (LPN) G, contracted travel CNA J, contracted travel CNA K, certified medication aide (CMA) H, and CNA I. The following nursing staff members who worked on 7/11/26 did not receive the education or competencies described in the POC: CMA H, CNA I, CNA D, and CNA F. The following nursing staff members who worked on 7/12/26 did not receive the education or competencies described in the POC: CMA H, CNA I, and CNA F. The following nursing staff members who worked on 7/13/26 did not receive the education or competencies described in the POC: CNA F and contracted travel CNA L. The following nursing staff members who worked on 7/14/26 did not receive the education or competencies described in the POC: CNA I, CMA H, contracted travel CNA M, contracted travel CNA N, and CNA E. The following nursing staff members who worked on 7/15/26 did not receive the education or competencies described in the POC: LPN G and contracted travel CNA O. 4. Review of the provider’s Allen Wing Resident on Falling Leaf Program revealed that the document was last audited on 4/27/26. “Qualifier: …the following names are those who meet criteria based upon volume of falls and/or fall risk assessment scores. Please be mindful within your own rounds as well as in educating your department associates of these folks and to intervene with support (or remain with the person until help arrives) should they be attempting to self-transfer, reaching to the floor, etc.” Resident 2 was included on that list. 5. Review of the provider’s March 2025 Fall Prevention and Post Fall policy revealed that the “Falling Leaf Program serves as a fall prevention	F0689	On 07/16/26, Social Services completed an audit of all Falling Leaf door magnets and foam leaves to verify residents on the Falling Leaf program had the appropriate identifiers in place. Identified concerns were corrected when found. All facility nursing staff are required to complete F689 education and competency validation prior to working independently and prior to providing resident care. The education includes resident safety, fall risk reduction, supervision, safe bed height, change-of-shift walking rounds, visual safety checks based on the resident's plan of care, resident-specific hourly safety checks when indicated, placement of tent lights and call lights, colored call light meanings, accessing care plans and pocket care plans, and documentation of new interventions following a fall. Education also includes how to identify residents with facility-designated fall risk alerts or identifiers, including the Falling Leaf program, and how staff are expected to respond to residents attempting unsafe movement. Staff competency is validated through verbal review, written review, and/or return demonstration.	08/01/2026

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F0689 SS = E	Continued from page 2 initiative for residents with impaired mobility, utilizing identification markers and specialized interventions to reduce fall risks." "Placement of Falling Leaf Identifiers… A magnet at the left corner of the resident's door. A foam leaf attached to the resident's wheelchair and/or walker." Pictures were provided in the policy of the magnets with leaves on them. 6. Observation on 7/14/26 at 4:45 p.m. revealed that resident 2 did not have a foam leaf on her wheelchair. CNA I confirmed there was no leaf. 7. Interview on 7/15/26 at 9:07 a.m. with assistant director of nursing (ADON) C revealed that she expected the residents on the Falling Leaf Program to have both a leaf magnet on their bedroom doorframe and a leaf attached to their walker or wheelchair. She confirmed that sometimes the resident's wheelchairs get mixed up or the leaves fall off the walker or wheelchair. 8. Interview on 7/15/26 at 9:13 a.m. with director of nursing (DON) B revealed that he did not provide a reason why some of the nursing staff members did not complete the education or had competencies completed yet. He confirmed that CNAs D, E, F, and I, CMA H, and LPN G had all worked shifts on or after the last correction date of 7/10/26 and did not complete the education or competencies. He was providing the education in-person at shift change meetings. He was the only one providing the education. He did not expect the contracted travel CNAs to complete the education as the education "was more internally focused." There was a resource binder for the contracted travel staff located at the nurse's station. The binder included facility policies, recent education, descriptions of what the different colored call lights mean, among other things. 9. Observation on 7/15/26 at 10:00 a.m. revealed that there was no resource binder located at the nurse's station. 10. Interview on 7/15/26 at 10:03 a.m. with LPN P revealed that she confirmed there was no resource binder at the nurse's station. The contracted travel staff would use the printed pocket care plans (a document that identifies residents' care needs and interventions) to identify how to take care of each resident.	F0689	A standardized contracted/agency staff orientation packet was updated and placed in the resource binder at the nurses station. The resource binder includes resident safety practices, fall risk reduction expectations, facility-designated fall risk alerts or identifiers, call light system information, colored call light meanings, accessing care plans and pocket care plans, and where to locate facility resources. Moving forward, contracted/agency staff will receive facility-specific orientation through the orientation packet/resource binder prior to providing resident care. The charge nurse/designee is responsible for directing contracted/agency staff to the resource binder and orientation packet. The DON, ADON, Staff Development designee, or other designee will audit facility nursing staff education and competency records to verify required F689 education and competency validation were completed prior to the staff member working independently or providing resident care. Audits will be completed weekly for 8 weeks, then monthly for 2 months. Identified concerns will be corrected at the time of discovery. The DON, ADON, Social Services designee, or other designee will audit residents identified at risk for falls, including residents on the Falling Leaf program, to verify current fall risk assessments, resident-specific interventions, care plan accuracy, pocket care plan accuracy, Falling Leaf identifier placement, and implementation of interventions.	08/01/2026

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F0689 SS = E	Continued from page 3 11. Observation and interview on 7/15/26 at 10:15 a.m. with life enrichment assistant Q revealed that resident 2 was in her wheelchair in the dining room. There was no foam leaf attached to her wheelchair. Life enrichment assistant Q verified that resident 2 did not have a leaf on her wheelchair. She stated, “If I don’t see one [a leaf], then I assume she is not on it [the fall leaf program].” 12. Interview on 7/15/26 at 10:35 a.m. with contracted travel CNA O revealed that he confirmed there was no reference binder for the contracted travel staff. That day was his second shift working there. He did not receive any education or orientation from the provider before starting work at that facility. He did not know what the Falling Leaf Program was. He did not know what the different colored call lights meant. 13. Interview on 7/15/26 at 10:53 a.m. with ADON C revealed that the resource binder should have been located at the nurse’s station. She confirmed she could not find it. The information usually in that binder included the fall policy, explanations about what the different colored call lights meant, resident laundry instructions, and how to read and use the pocket care plans. The charge nurses were responsible for ensuring that the contracted travel staff knew what the resource binder was, where to find it, and what was in it. She confirmed that she provided some of the required education as part of the POC, but DON B was the main person to provide the staff education. There was a list of staff members who had completed the education and who had yet to complete it, and DON B kept track of that list and updated it as needed. She confirmed that she provided the education and competency test to CNA I that morning. 14. Interview on 7/15/26 at 11:07 a.m. with administrator A revealed that he expected the staff members to have received the POC education and competencies checked by the last correction date. He would have expected the contracted travel staff to be included in the education since the education was provided in-person at the shift change meetings.	F0689	Audits will include verification of Falling Leaf doorframe magnets and wheelchair/walker foam leaves, as applicable. The charge nurse/designee will verify the contracted/agency staff resource binder and orientation packet are present at the nurses station weekly for 8 weeks, then monthly for 2 months. Missing or incomplete resources will be corrected at the time of discovery. Audit results will be reviewed by the DON/ADON or designee during the monitoring period. Audit results will be reported to the QAPI Committee monthly for 3 months. The QAPI Committee will review findings, trends, and corrective actions to determine if additional action is needed to maintain compliance.	08/01/2026