

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

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| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435127</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X3) DATE SURVEY COMPLETED<br><br><b>06/10/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DOW RUMMEL VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1321 W DOW RUMMEL ST , SIOUX FALLS, South Dakota, 57104</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |                            |
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| F0000                                                         | INITIAL COMMENTS<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 6/10/26. The area surveyed was the quality of care for a resident who fell and injured her left hand and received treatment at an emergency room. Dow Rummel Village was found not in compliance with the following requirement: F689.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                         |  | F0000                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     | 7/10/2026                  |
| F0689<br>SS = G                                               | <p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), record review, interview, and policy review, the provider failed to ensure an environment free of accident hazards and supervision when the staff did not complete hourly safety checks according to the provider's policy and left a resident's bed in an elevated position for one of one sampled resident (1) who was not checked on for four hours and subsequently fell out of bed onto the floor and sustained a laceration to her left hand that was sutured in an emergency room.</p> <p>Findings include:</p> <p>1. Review of the provider's 4/17/26 SD DOH FRI, revealed that on 4/16/26, resident 1 was found lying on the floor in her room at approximately 9:00 a.m. There was "blood all over the floor, and to her bilateral [both] hands and right arm." She was</p> |                                                                         |  | F0689                                                                                                       | <p>Resident 1 was assessed after the fall was discovered on 04/16/26 and was transferred to the emergency room for evaluation and treatment. The physician and responsible party were notified after the fall was discovered and prior to the resident returning to the facility.</p> <p>Upon return to the facility, nursing reviewed the ED discharge paperwork. The instructions included keeping the wound clean and dry, limiting significant bending of the wrist/hand until sutures were removed, following up with orthopedic hand, and returning for new or worsening symptoms or other concerns. The order was clarified/changed to allow suture removal to be completed at the facility. Nursing assessed Resident 1 upon return, including vital signs, pain, functional status, skin/wound status, and left hand brace placement. The resident was assisted back to bed, positioned for comfort, and the tent light and call light were placed within reach. Nursing reviewed the ED medication list and faxed the medication list to the primary care provider for review.</p> <p>(continued on next page)</p> |                                                     |                            |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><br><i>Christopher Hahn</i> |  | TITLE<br><br>Administrator of Health Care Services | (X6) DATE<br><br>7/2/2026 |
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| F0689<br>SS = G                                               | <p>Continued from page 1<br/>bleeding from a skin tear to her left hand, a potential head injury, complaints of back pain, and a swollen right knee. She was transferred to the hospital emergency room (ER) for evaluation. Resident 1 returned to the facility on 4/16/26 with the laceration to her left hand sutured and a "cock-up wrist splint [a rigid brace designed to hold the wrist in a neutral position] to be applied."</p> <p>The provider's investigation as documented on the SD DOH FRI revealed that the staff last checked on resident 1 on 4/16/26 at 5:00 a.m., and that her bed at the time of the incident was found in an elevated position. The provider's FRI did not indicate why resident 1 was not monitored by staff members for approximately four hours or why her bed was in an elevated position. Following this incident, a scoop mattress (specialized medical or care-facility mattress designed with raised edges and a lower center) was provided to the resident for "border definition."</p> <p>Caregiver staff members present during that shift were educated on end-of-shift rounding (checking on residents' status and assistance needs) expectations with the oncoming staff members, and further staff education was to be provided on 4/22/26. There was no documented indication that audits were performed after resident 1's fall.</p> <p>2. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the facility on 1/29/26. Her 2/4/26 Brief Interview of Mental Status (BIMS) assessment score was a 5, which indicated she had severe cognitive impairment. Her diagnoses included difficulty in walking, weakness, and osteoarthritis (gradual breakdown of the joint).</p> <p>Resident 1's 2/4/26 Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) indicated she was dependent on staff members for all of her care needs. She used a wheelchair and had impairment (difficulty with moving joints, feeling sensations, or gripping objects) on both sides of her upper body. While in bed, she required substantial assistance to roll from lying on her back to the left and right side.</p> <p>Resident 1's 6/10/26 care plan had a 2/2/26 dated focus area that indicated she had an activities of daily living self-care performance deficit with limited mobility and weakness. The 3/26/26 revised interventions for that focus included that resident 1 needed substantial assistance by one staff member</p> |                                                                            |  | F0689                                                                                                       | <p>On 04/20/26, the interdisciplinary team reviewed Resident 1's fall, current fall prevention interventions, bed height, supervision needs, and plan of care. A scoop mattress was implemented on 04/20/26 as a new fall prevention intervention for border definition and safety.</p> <p>On 04/22/26, nursing staff education was completed regarding fall prevention, safe bed height, visual safety checks, change-of-shift walking rounds, and following the resident-specific plan of care. Education included expectations for completing walking rounds with the off-going and oncoming staff during shift change.</p> <p>The fall risk assessment was updated on 04/30/26 and reflected a fall risk score of 17.</p> <p>(continued on next page)</p> |                                                     | 7/10/2026                  |

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| F0689<br>SS = G                                               | <p>Continued from page 2</p> <p>to turn and reposition in bed, needed 2 staff members and a mechanical lift to transfer from one area to another. A 3/26/26 focus area indicated that she was at a low risk for falls related to her being unaware of her safety needs, and her total dependence on staff members for transfers. The 3/26/26 interventions included "anticipate and meet my needs."</p> <p>A 4/16/26 nurses' progress note revealed that on 4/16/26 resident 1 had an "unwitnessed fall" with "blood all over the floor, her bilateral hands and right arm." "Her left hand was noted to have significant bleeding, open to the top of the hand near the knuckle." "Measured the area after cleansing it: 7.1 cm [centimeters] X [by] 1.5cm X 0.5 cm." Resident 1 was sent to the emergency room for treatment and returned to the facility on 4/16/26 at approximately 3:40 p.m. with a "black brace" on her left hand. The nurse's progress note indicated that she had ten sutures on her left hand.</p> <p>Her 4/20/26 nurses' progress notes revealed the interdisciplinary team reviewed resident 1's fall and implemented a scoop mattress on her bed for her "safety".</p> <p>Resident 1's 4/16/26 ER notes included that there was an X-ray of her left hand that did not reveal a fracture. There was a laceration of her left dorsal (back of the) hand that spanned the mid-dorsal hand (over the knuckle joint) to the proximal phalanx (over the base of the finger). Her head and cervical spine were evaluated, and there were no acute findings. Resident 1 was discharged back to the facility at 3:38 p.m. in stable condition with sutures to her left hand laceration and a hand splint.</p> <p>3. Interview on 6/10/26 at 1:41 p.m. with assistant director of nursing (ADON) B regarding resident 1's incident on 4/16/26 revealed she reviewed the 4/16/26 video camera footage from 7:08 a.m. through 9:05 a.m. of the hallway where resident 1's room was located. She confirmed, through video footage and her investigation, that resident 1 was last checked on by a staff member at approximately 5:00 a.m. ADON B indicated resident 1's incident was an "unwitnessed fall", her bed was "higher than it should have been", and that she did not investigate why the bed was "that high" at the time of resident 1's fall.</p> <p>ADON B indicated that resident 1 "is not one who normally" attempted to get out of bed on her own, but she may have "rolled over" and fell out of her bed. Resident 1 needed the use of a full body lift (a</p> |                                                                            |  | F0689                                                                                                       | <p>The DON/designee reviewed current residents to identify residents at risk for falls, residents with frequent falls, residents requiring assistance while in bed, residents requiring mechanical lift transfers, residents with cognitive impairment, and residents who may be unable to request assistance or ensure their own safety. Residents identified with frequent falls or increased fall risk were reviewed to determine if current interventions remained appropriate, including whether they met criteria for the facility's Falling Leaf program and resident-specific hourly safety checks. Care plans were reviewed and updated as needed. Resident beds were observed to ensure they were maintained at the lowest safe position when not actively providing care.</p> <p>(continued on next page)</p> |                                                     | 7/10/2026                  |

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| F0689<br>SS = G                                               | <p>Continued from page 3</p> <p>mechanical lift and sling used to lift a person's full body) for getting out of bed at the time of her 4/16/26 fall.</p> <p>ADON B stated that staff members were to visually observe all residents at least once per hour to ensure their safety. She stated that she educated the staff members working on 4/16/26, which included ensuring "walking rounds" were completed during the staff member's change of shift. She indicated there was no documentation of that education. On 4/22/26, ADON B conducted an all-staff meeting education that included the staff were to ensure "walking rounds" were completed during the change of shift. The change of shift occurred at approximately 6:00 a.m., when the day staff members were coming on duty and the night shift staff members were going off duty. The day shift staff members and night shift staff members were to visually check on each resident, together, before the off-going staff member left. ADON B expected resident 1 to be checked on at a "minimum of two hours". She acknowledged the provider's policy was for each resident to be checked on every hour.</p> <p>4. Interview on 6/10/26 at 2:40 p.m. with registered nurse (RN) C regarding resident 1's unwitnessed fall on 4/16/26 revealed she was working the morning of 4/16/26. After resident 1 was found in her room by certified medication aide (CMA) D, RN C stated that he indicated he was not able to see her at the start of his shift, and had not seen her until he found her on the floor around 9:00 a.m. CMA D did not explain to RN C why he was not able to see resident 1 until 9:00 a.m.</p> <p>RN C stated that when she entered resident 1's room, her bed was waist-high, and moved to the right, away from the window. She was between the wall and bed, [CMA D] had moved her bed, "so she wasn't squished in there." Resident 1's left hand had a skin tear, and there was lots of blood. Resident 1 was evaluated by RN C. Her family and physician were notified, and resident 1 was transferred to the ER. RN C was unable to recall any incident or staffing issues that would have resulted in resident 1 not being checked on for approximately four hours.</p> <p>5. Interview on 6/10/26 at 3:42 p.m. with administrator A and ADON B revealed that every Monday morning, the interdisciplinary team (group of people with different skills and specialties who work closely together to solve a complex problem or care for a person) met, reviewed the resident falls that had occurred the previous week, and discussed if</p> |                                                                         |  | F0689                                                                                                       | <p>The Administrator, DON, and interdisciplinary team, in collaboration with the Medical Director, reviewed and revised facility processes related to resident safety and fall prevention, supervision, resident-specific rounding expectations, change-of-shift walking rounds, safe bed heights, and placement of resident safety devices, including tent lights and call lights.</p> <p>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.</p> <p>(continued on next page)</p> |                                                     | 7/10/2026                  |

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>435127</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X3) DATE SURVEY COMPLETED<br><br><b>06/10/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DOW RUMMEL VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1321 W DOW RUMMEL ST , SIOUX FALLS, South Dakota, 57104</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                     | (X5)<br>COMPLETION<br>DATE |
| F0689<br>SS = G                                               | <p>Continued from page 4<br/>any new interventions were needed to be implemented to prevent further falls for those residents.</p> <p>ADON B confirmed that on 4/16/26, resident 1's bed was in an elevated position. She stated that staff members would raise the bed when providing the resident personal care while they remained in bed, and those staff members would often "forget" to lower the bed when the care provided was completed. Resident 1's scoop mattress was implemented on 4/20/26.</p> <p>ADON B indicated she had completed audits through observation to ensure the beds were maintained at the correct height. She confirmed there were no audits related to staff members completing rounds before leaving their shift.</p> <p>6. CMA D was no longer employed by the provider at the time of the survey and was unavailable for interview.</p> <p>7. Review of the provider's January 2026 Resident Call System and Hourly Safety Checks policy revealed, "Staff are required to respond promptly to all call lights and complete required hourly safety checks." "Hourly Safety Checks". "Visually confirm the resident's presence and safety."</p> <p>Review of the provider's March 2025 Fall Prevention and Post Fall policy revealed, "nurse's notes should include the following information:" "New fall intervention implemented to prevent the recurrence of falls". "The healthcare team will discuss the residents' [resident's] fall at the next fall's [fall] review and agree on at least one new intervention for the resident's fall risk care plan."</p> <p>Review of the provider's January 2025 Abuse Prevention, Intervention, Reporting, and Investigation policy revealed, "Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. May be intentional[,] such as withholding or omitting care[,] or unintentional where the caregiver should have known that care was needed, but it [was] not provided."</p> | F0689                                                                      | <p>The DON/designee will audit resident safety practices, including bed height, implementation of fall interventions, tent light/call light placement as applicable, completion of change-of-shift walking rounds, and completion of increased monitoring for residents requiring resident-specific safety checks, including residents in the Falling Leaf program. Audits will be completed on all shifts 5 times per week for 4 weeks, then weekly for 8 weeks. Identified concerns will be corrected at the time of discovery, and staff will receive immediate re-education and/or corrective action as appropriate. Audit results will be reviewed by the Administrator and DON weekly and reported to the QAPI Committee monthly for 3 months. The QAPI Committee will review audit findings, trends, and corrective actions to determine if additional action is needed to maintain compliance.</p> |                                                     |                            |