

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/21/2024
NAME OF PROVIDER OR SUPPLIER  Dow Rummel Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1321 W Dow Rummel St Sioux Falls, SD 57104	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49395</p> <p>Based on interview, record review, and policy review, the provider failed to develop comprehensive care plans to include interventions for documented food allergies and/or intolerance's for four of four sampled residents (1, 2, 3, 4,) which included one who had been served shrimp [NAME] and developed an allergic reaction. Findings include:</p> <p>1. Interview on 8/21/24 at 10:05 a.m. with certified nursing assistant (CNA) I revealed:</p> <ul style="list-style-type: none"> <li>*She had worked for the provider for two years.</li> <li>*She would have referred to the pocket care plan to know how to care for her residents.</li> <li>*She would have assisted residents in the dining room at mealtimes.</li> <li>*The pocket care plan did not list resident 1's shellfish allergy.</li> <li>*She did not know where to find out if a resident had a food allergy or food intolerance.</li> <li>*She would have asked the nurse if she had questions or concerns.</li> </ul> <p>2. Interview on 8/21/24 at 10:10 a.m. with CNA J revealed:</p> <ul style="list-style-type: none"> <li>*She had worked for the provider for 3 weeks.</li> <li>*She would have referred to the pocket care plan for details of the resident's needs.</li> <li>*She was not aware of where to find a list of resident's food allergies or intolerance.</li> </ul> <p>3. Interview on 8/21/24 at 12:12 p.m. with registered nurse (RN) G and licensed practical nurse (LPN) H revealed:</p> <ul style="list-style-type: none"> <li>*When asked where nursing staff would find a list of a resident's food allergies, LPN H stated information would be included in their care plan.</li> </ul> <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 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
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*LPN H and RN G both agreed that a resident's food allergy should have been on the resident's care plan.</p> <p>*When asked how CNAs would know if a resident had a food allergy, they agreed the CNAs would be expected to ask nursing or refer to the resident's EMR or meal tray ticket.</p> <p>4. Interview on 8/21/24 at 12:30 p.m. with Certified Dietary Manager (CDM) C and Director of Culinary Services (DCS) D revealed:</p> <p>*Resident food preferences or allergies were not included in the resident care plans because those changed of frequently. In the past, some residents had their dislikes listed in the care plan, and requested that food item, and that raised concerns about not following their care plan.</p> <p>*DCS D agreed that it would be important to have residents' food allergies listed in the residents care plan.</p> <p>*CDM C stated that food preferences and food intolerance's were discussed during the residents admission assessment and reviewed quarterly during their care conferences. Food allergies were communicated from the nursing staff at those meetings.</p> <p>*Resident food preferences, intolerance's, and allergies were not included in the residents care plan. They were located on the residents meal tray ticket and available in the kitchen to all staff.</p> <p>5. Interview on 8/21/24 at 1:04 p.m. with resident 4 with a Brief Interview for Mental Status (BIMS) of 15 which indicated her cognition was intact revealed:</p> <p>*Resident had an intolerance to onions which gave her a headache.</p> <p>*When asked if she is served onions, she said sometimes and stated, It is sometimes hard to avoid eating onions here because they put onions in everything.</p> <p>6. Interview on 8/21/24 at 1:19 p.m. with director of nursing (DON) B regarding resident food allergies and intolerance's revealed:</p> <p>*Direct care staff would use the pocket care plans for direction when providing assistance to residents.</p> <p>*He agreed resident food allergies should be included in care plans and on the pocket care plans used by the CNAs.</p> <p>7. Record review of resident 1's EMR revealed:</p> <p>*The resident had a documented shellfish allergy.</p> <p>*The resident's shellfish allergy was not documented in her care plan.</p> <p>8. Record review of resident 2's EMR revealed:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*The resident had a documented shellfish allergy.</p> <p>*The resident's shellfish allergy was not documented in her care plan.</p> <p>9. Record review of resident 3's EMR revealed:</p> <p>*The resident had a documented allergy to nuts.</p> <p>*The resident's nut allergy was not documented in her care plan.</p> <p>10. Record review of resident 4's EMR revealed:</p> <p>*The resident had a documented allergy to chocolate, popcorn, and pork.</p> <p>*The resident's allergy to chocolate, popcorn, and pork was not documented in her care plan.</p> <p>10. Review of the provider's undated pocket care plans revealed:</p> <p>*Resident 1's shellfish allergy had not been listed</p> <p>*Resident 2's shellfish allergy had not been listed.</p> <p>*Resident 3's nut allergy had not been listed.</p> <p>*Resident 4's chocolate, popcorn, and pork allergies had not been listed.</p> <p>11. Review of the provider's 3/15/2023 Care Plans Policy revealed:</p> <p>*A comprehensive care plan was developed for each resident that included measurable goals and timetables to meet a resident's medical, nursing, mental and psychosocial needs that were identified in their comprehensive assessment.</p> <p>*The care plan focused on the course of action needed to attain or maintain a resident's highest practicable physical, mental, cognitive, medical, and psychosocial well-being.</p>

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<p>F 0806</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>49395</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure resident (1) who had an allergic reaction that required the administration of an antihistamine due to a shellfish allergy was identified by the dietary staff before being served shrimp Alfredo. Findings include:</p> <p>1. Review of the provider's 8/16/2024 SD DOH FRI revealed:</p> <p>*On 8/16/24, the provider served shrimp [NAME] for lunch. The nurse had looked up residents who had shellfish allergies and reminded the certified nursing assistants (CNA) to be careful of cross-contamination. The nurse then questioned resident 1's meal and confirmed that resident 1 was served the pureed shrimp Alfredo. Resident 1 was then taken to the nurses' station for assessment where she started to develop a rash around the mouth and redness in her mouth and throat. The nurse obtained orders to administer Benadryl. The Benadryl was administered to resident 1 once it had been received.</p> <p>2. Observation on 8/21/24 at 11:30 a.m. of the lunch service with [NAME] E and [NAME] F revealed:</p> <p>* [NAME] E and [NAME] F referred to the resident's tray ticket for the resident's preferences for each meal.</p> <p>*The food tray ticket included the resident's diet, diet texture, adaptive equipment, allergies, and menu preference.</p> <p>*Cook F referenced the tray tickets and placed food items on the resident's plate.</p> <p>3. Interview on 8/21/24 at 11:45 a.m. with [NAME] E and [NAME] F revealed:</p> <p>*On 8/16/24 [NAME] F served shrimp [NAME] to resident 1.</p> <p>*Cook F admitted that she had missed the documented shellfish allergy on resident 1's tray ticket on 8/16/24.</p> <p>*Cook F felt that a resident's food allergies should be highlighted on the tray ticket, and stated it would make dietary staff more aware of the resident's food allergies.</p> <p>*Cook F stated that nursing staff should have made dietary staff aware when they had known that shellfish was on the menu, and there were residents with a documented shellfish allergy.</p> <p>*Cook E stated nursing did not communicate with them until the food was already served to resident 1.</p> <p>*When asked about substitutes for residents with food allergies, [NAME] E stated that residents on puree diets did not have a choice because the menu does not offer pureed food and most residents with puree diets cannot communicate their preferences.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Cook E stated that the dietary staff would go to each resident's room and would ask them if the resident wanted the main meal being served or if they would want a substitute food item. However, they would not do this for residents on puree diets because there was not a puree option on the menu. She felt this may have been why they would have not looked at resident 1's tray ticket as closely on 8/16/24.</p> <p>*When asked what she would do if she had realized that resident 1 had a shellfish allergy, [NAME] F stated she would have made something else for her to eat.</p> <p>4. Interview on 8/21/24 at 12:30 p.m. with Certified Dietary Manager (CDM) C and Director of Culinary Services (DCS) D revealed:</p> <p>*Tray tickets were printed three times a week. There is a specific section where allergies are listed.</p> <p>*It is the responsibility of staff to reference the tray tickets regarding resident's food allergies.</p> <p>*The shrimp [NAME] was permanently taken off the menu and replaced with chicken Alfredo.</p> <p>*Dietary staff should be offering residents on a puree diet an alternative food option when needed.</p> <p>*The menu substitution lists referred to the 5/27/2020 Offering Food Replacements at Meal Times Policy was not currently available to the dietary staff in the kitchen.</p> <p>5. Review of Resident 1's electronic medical record revealed:</p> <p>*Resident had a documented shellfish allergy.</p> <p>6. Review of resident 1's 8/16/24 nursing progress note revealed:</p> <p>*Nursing was advised that dietary was serving shellfish (shrimp Alfredo) for lunch. Nursing reviewed which residents with shellfish allergies. Nursing reminded staff the certified nurse aides (CNA) to be careful of cross contamination and residents who have allergies. The resident was recently switched to a puree diet. The nurse observed the table where resident one was being assisted by staff and questioned the meal resident one was provided and was currently eating. It is reported that the dietary cook had given the resident the pureed shrimp Alfredo. Resident was immediately brought to the nurses' station for examination and monitoring. It was noted that the nurse was able to see resident 1 started to develop a rash on the corners of her mouth. It was also noted that resident 1's mouth and throat were red. Resident 1 was able to speak one-word answers during the examination. Orders for Benadryl and an epinephrine injection were obtained. The Benadryl was given when it arrived. It was noted that the Benadryl was effective, and the epinephrine injection was not needed.</p> <p>7. Review of the provider's 2/2024 job description for a Licensed dietary cook revealed:</p> <p>*Job duties included:</p> <p>-Reviewing menus before food preparation and following recipes.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Inspecting special diet trays for accuracy.</p> <p>-Coordinating dietary services with other departments.</p> <p>-Assuming authority, responsibility, and accountability of the cook.</p> <p>-Processing and following diet changes and new diets received from nursing services.</p> <p>-Preparing food for therapeutic diets in line with planned menus and standardized recipes.</p> <p>8. Review of the provider's 5/27/2020 Offering Food Replacements at Mealtimes Policy revealed:</p> <p>*If an individual is not eating (or foods) served, the Nursing Associates in responsible for asking why and for verbally offering a suitable food replacement. (Please see the Menu Substitution Lists in the Menus/Therapeutic Diets Section.) The individual is encouraged to give input for his/her choice of substitution. A minimum of three substitutions should be offered.</p> <p>*For those on special diets, be sure the food replacement offered are appropriate for the therapeutic and mechanically altered diet order.</p>		