| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435127 | A. Building<br>B. Wing | 10/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Dow Rummel Village | 1321 W Dow Rummel St<br>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) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435127 | A. Building<br>B. Wing | 10/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Dow Rummel Village | 1321 W Dow Rummel St<br>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) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, interview, observation, record review, and policy review, the provider failed to ensure certified medical assistant (CMA) G and certified nursing assistant (CNA) I followed facility policy to provide individualized care for one of one resident (1) and resulted in the resident having to be transferred to the emergency department. Resident 1 received a large laceration to her right lower leg that required sutures. 1. Review of the provider's 10/4/25 submitted FRI to the SD DOH regarding resident 1 revealed on 10/3/25 at around 6:46 p.m., certified medication aide (CMA) G and certified nursing assistant (CNA) did not follow resident 1's comprehensive care plan that indicated the resident was to be assisted with transferring by two staff members with the use of the sit-to-stand (a mechanical lift used to assist from a seated to a standing position) which resulted in the resident receiving a large laceration to her right lower leg that required the resident to be sent to the emergency room (ER) for sutures. On 10/3/25 at 6:46 pm. CMA G and CNA I transferred resident 1 with a stand and pivot (when assisted to a standing position, the resident then turns their body to move to another surface) transfer from her wheelchair to her bed. Interviews with CMA G and CNA I during the provider's investigation revealed the resident was anxious at that time and felt it would have caused the resident to have increased anxiety to use the sit- to -stand mechanical lift .During the stand and pivot transfer, the resident's right leg was positioned next to CNA I's left leg. After the transfer, blood was found on the resident's right pant leg and CNA I's shoe. On 10/3/25 at 6:52 p.m. CNA I informed registered nurse (RN) C of the incident with resident 1. RN C and licensed practical nurse (LPN) F assessed the resident, discovered a large laceration to the resident's right lower leg, and determined the resident needed additional care that they were not able to provide at the facility. A telemedicine service was consulted and determined resident 1 needed to go to the emergency room (ER) for sutures to close the laceration. On 10/3/25 at 7:55 p.m. resident 1 left the facility and was transferred to the ER via ambulance. The resident returned to the facility at 12:51 a.m. on 10/4/25 with sutures to her right lower leg. Wound dressing and treatment orders were received from the ER and orders for the resident to follow up with her primary physician in 10 days for removal of the sutures. Resident 1's daughter was updated of events throughout and expressed an understanding of the treatment plan. After the incident on 10/3/25 resident 1's care plan was updated to indicate the resident was to be assisted with transferring by two staff members and the use of a total body lift (a mechanical life and sling used to lift a person's full body) lift until the resident's leg laceration was healed. It was determined the facility would reevaluate after the laceration healed, the resident's abilities to transfer would be re-evaluated. On 10/6/25 at 6:00 p.m. director of nursing (DON) A interviewed CNA I and educated her that she did not follow resident 1's care plan when she decided to independently transfer the resident using the stand and pivot maneuver rather than the sit-to-stand mechanical lift. CNA, I agreed with DON A that she did not follow the provider's policy for providing care according to the resident's care plan. Formal documentation was completed for CNA I related to the incident that occurred on 10/3/25 with resident 1. CNA I had no previous documentation of resident care concerns prior to that time.2. Review of resident 1's electronic medical record (EMR) revealed resident 1's Brief Mental Status (BIMS) score was 0, which indicated her cognition was severely impaired. Her diagnoses include Alzheimer's disease, dementia (a group of symptoms affecting memory, thinking, and social abilities),anxiety, iron deficiency anemia (low iron in blood), localized edema (tissue swelling), and chronic peripheral vascular disease (narrowed or blocked arteries) and hypertension (high blood pressure). On 10/13/25 orders were received from resident 1's primary physician to apply an Ace elastic bandage wrap to the right lower extremity. Apply the ace wrap distal (away from) the laceration, using 50% overlap and 50% stretch, and make sure the knee is bent and the ankle is at 90 degrees to her right lower extremity. Mepilex (foam absorbent dressing) may be applied over pressure point as needed. Remove the ace wrap every eight hours to assess pressure points and provide skin cares. Notify the provider if pedal pulses are absent or there are pressure concerns prior to application and reapplication of wound. 3. Interview and observation on 10/29/25 at 1:25 p.m. with CMA J and CNA H while transferring resident 2 from her wheelchair to her recliner in her room using the sit-to-stand mechanical lift revealed two staff are required to assist with the use of the sit-to-stand mechanical lift.CNA H and CMA J indicated that the use of the sit-to-stand mechanical lift required two staff members to use it safely. There were no concerns with the transfer observed.4. Interview on 10/29/25 at 3:06 p.m. with CNA I revealed resident 1 was more agitated than usual on the evening of 10/3/25. She stated she had asked CMA |