

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>435127 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>11/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Dow Rummel Village |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
|--|---|
| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the South Dakota Department of Health (SD DOH) Facility-Reported-Incident (FRI), interview, record review, observation, and policy review, the provider failed to ensure one of one resident (1) had not received incorrect medications, which led to the resident vomiting, requesting a transfer and evaluation at the local emergency department, and anxiety related to medication administration. Findings include: 1. Review of the provider's 10/29/25 final FRI submitted to the SD DOH revealed that on 10/29/25, certified medication aide (CMA) D administered medications to resident 1 that were prescribed for resident 2.</p> <p>CMA D recognized that she had given the medications to the incorrect resident and reported it to licensed practical nurse (LPN) H, who was the charge nurse on duty at the time.</p> <p>The provider contacted their telemedicine service who recommended to monitor resident 1's vital signs and blood sugar levels. Approximately one hour later, a different staff member reported to LPN H that resident 1 had an emesis (vomiting). LPN H contacted the telemedicine service again to report that resident 1 had symptoms of nausea/vomiting, diarrhea, being light-headed, and appeared worked up [and was] worried about receiving the wrong medications. Resident 1 was transferred by ambulance to a local emergency department for evaluation. She returned to the facility later that evening. Assistant director of nursing (ADON) C completed and submitted the final report to the DOH.</p> <p>CMA D was removed from performing medication administration while the investigation was completed. When interviewed by ADON C, CMA D reported that she had prepared the medications for administration for resident 2. She followed resident 2 and another staff member into the dining room. At that time, CMA D mistook resident 1 for resident 2 and gave resident 2's prepared medications to resident 1 by mistake. CMA D recognized her mistake when she looked at the room number and name on the inhaler for resident 2 and reported her error to LPN H.</p> <p>Before CMA D resumed medication administration duties, ADON C reviewed the medication administration policy with her, observed her for four hours while performing medication administration, and completed the Medication Administration Clinical Skills Checklist from the South Dakota Board of Nursing website. After the error occurred, resident 1 requested that the medication aides pop out the medications in front of her so she could verify the medication she was being given, and the facility complied with that request.</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 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:<br><br>435127   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>11/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Dow Rummel Village   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>2. Review of resident 1's electronic medical record (EMR) revealed that she was admitted on [DATE]. She had the following diagnoses: Left pelvic fracture, Paroxysmal Atrial fibrillation (short episodes of irregular heartbeats), Type 2 Diabetes Mellitus (T2DM) with diabetic chronic kidney disease (a condition involving disruptions in how the body regulates blood sugar, with associated kidney function issues), and Occlusion and stenosis of unspecified carotid artery (arrowing or blockage of one or both carotid arteries in the neck).</p> <p>On the morning of 10/29/25, resident 1 received the following medications in error: Aspirin (a nonsteroidal anti-inflammatory drug), Budesonide (a corticosteroid), Calcium citrate (a calcium supplement), Vitamin D3 supplement, woman's multivitamin supplement, diltiazem (used to relax and widen blood vessels), Jardiance (used to treat diabetes), Metoprolol (used to treat high blood pressure), Miralax (a laxative), Pantoprazole (used to treat acid reflux), Pioglitazone (used to treat diabetes), Pravastatin (used to treat high cholesterol), Senna (a stool softener), Gabapentin (used to treat nerve pain), and Venlafaxine (used to treat anxiety and depression).</p> <p>After receiving the above medications in error, her vital signs were measured, and the on-call provider was notified. The on-call provider ordered for the staff to monitor her vital signs and blood sugar checks every four hours for 24 hours.</p> <p>Resident 1 was assisted back to her room after breakfast and was informed of the medication error. She denied feeling nauseous, dizzy, short of breath, or lightheaded.</p> <p>At around 9:15 a.m. on 10/29/25, resident 1 had an episode of emesis (vomit). Her vital signs were measured again, and resident 1 reported feeling nauseous and lightheaded. Another 10/29/25 nursing note indicated the Resident appeared worked up worried about receiving the wrong medications. Resident 1 requested to go to the local emergency department for evaluation.</p> <p>Another 10/29/25 nursing progress note indicated Received call from [hospital emergency department] Dr. [name redacted] she reported resident is doing much better. [Resident 1's] nausea and dizziness are resolving. Dr. also reported her speech is better resident was [complaining] that she had lost her [voice.] but her speech was clear. Provider [the doctor] said she was possibly having a dissociative reaction.</p> <p>3. Interview on 11/12/25 at 2:58 p.m. with CMA D revealed that on the morning of 10/29/25, she had prepared resident 2's morning medications. Resident 2 usually ate breakfast in her room, so she prepared the medications and went walking to find the resident. She found resident 2 and another CNA at the ice machine and followed them both to the rehab dining room.</p> <p>Upon entering the rehab dining room, resident 1 was already seated at a table and greeting CMA D good morning. CMA D said that my brain got switched up and she mistakenly administered resident 2's medications to resident 1. She realized her mistake when she looked at resident 2's inhaler label. She did not administer resident 2's inhaler to resident 1. She notified the nurse immediately after she recognized her mistake. After that, she continued to prepare medications for a couple more residents until ADON C moved her from the medication administration duties to certified nursing assistant (CNA) duties. CMA D could not remember which other residents she gave medications to that morning after the medication administration error.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>435127  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>11/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Dow Rummel Village   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>CMA D confirmed that ADON C reviewed the medication administration policy with her before she was allowed to pass medications again. CMA D confirmed that ADON C followed her for several hours one morning to observe her passing medications before she could perform medication administration duties independently again.</p> <p>4. Interview on 11/12/25 at 3:30 p.m. with resident 1 revealed that she admitted to the nursing home due to a fall that resulted in a fractured pelvis. She expressed no concerns with her care but then stated there was a medication problem because she was given another person's medications. She felt bad that she had not asked questions at the time she was given those medications. The staff knew right away that they were not her medications, and she vomited shortly after. She said she was very upset about it and the staff offered to bring the medication cards to her so that she could verify for herself that it was her correct medications before they removed medications from the medication card to administer to her. She said they still did that.</p> <p>5. Interview on 11/12/25 at 3:38 p.m. with CMA E revealed that she was aware of the medication error that had occurred on 10/29/25 with resident 1. She was not educated about the incident, the medication administration policy, or other medication administration topics after the incident. When asked about the six rights to medication administration as listed in the provider's policy, CMA E was able to list four of the six rights.</p> <p>6. Interview on 11/12/25 at 5:01 p.m. with ADON C revealed that LPN H informed her immediately of the medication error with resident 1 on the morning of 10/29/25. She went to speak with CMA D to learn about what happened. She reassigned CMA D to work as a CNA while she conducted the investigation of the error. She had CMA D write down exactly what happened with the error for resident 1. She confirmed that they had not educated all the other staff who administered medications about the incident yet, and there was no other monitoring or auditing of medication administration other than the four hours she spent with CMA D on the morning of 11/4/25. The CMAs were scheduled to complete their annual medication administration refresher training by the end of the calendar year.</p> <p>7. Interviews on 11/12/25 at various times with several residents and family members revealed no concerns with the care that staff provided or medication administration.</p> <p>8. Observations on 11/13/25 from 7:44 a.m. to 8:34 a.m. of CMAs E and F revealed no concerns with their medication administration practices.</p> <p>9. Observation and interview on 11/13/25 from 7:45 a.m. to 8:30 a.m. with CMA F revealed that she had heard about the medication error on 10/29/25 from other staff members, but did not work that day. She completed a 20-hour medication aide class and test about two years ago and had received annual education assigned to her online last year. Most information was received through 1:1s (individual meetings) with ADON C. No additional education was received after the 10/29/25 medication error. She learned the six rights of medication administration and was able to list them.</p> <p>10. Interview on 11/13/25 at 8:38 a.m. with CMA E revealed that there was no formal education regarding medication administration after the 10/29/25 medication error occurred. She learned about the incident because she was working that day but did not hear about much else about it. CMA E indicated that ADON C hovered over us while they were performing medication administration that day on 10/29/25, but there was no formal conversation or discussion about how to administer medications correctly to residents to prevent a medication error.</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>435127   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>11/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Dow Rummel Village   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>11. Interview on 11/13/25 at 9:14 a.m. with LPN G and CMA F revealed that they both confirmed that there was no recent education provided regarding the correct procedures for medication administration to prevent medication errors. LPN G was not aware of the 10/29/25 medication error that occurred with resident 1. At times when there was new education, DON B would print out an email or a policy and requested staff to review and sign to indicate they understood the material. There was no education like that recently.</p> <p>12. Interview on 11/13/25 at 10:06 a.m. with administrator A revealed that he was informed of the medication error for resident 1 on 10/29/25. He confirmed he was not involved in the investigation or corrective actions, but DON B kept him informed of the situation.</p> <p>To protect resident 1, they contacted the telemedicine service provider for assessment and further orders. They sent resident 1 to the emergency department upon her request. To protect the other residents, they removed CMA D from medication administration duties until they could reeducate her and deem her competent to perform medication administration safely.</p> <p>As part of an investigation, he expected all parties to have been interviewed, not only from other staff members, but residents too. He expected that a quick huddle with all staff in charge of medications about protocol on how we do it [medication administration] should have been completed. When asked about his expectations for documenting education and auditing, he stated, I'd prefer more documentation than less. I always remind people that we can say we did all this stuff, but it's hard to prove that we did it.</p> <p>He stated that it probably would be a good idea to go through that [the medication administration education] with everybody. The leadership team had planned on including that information at their next nursing staff meeting. He confirmed that he did not know if the monitoring process was documented, but the nursing management team made more of a presence on the floor after the medication error incident.</p> <p>13. Interview on 11/13/25 at 10:44 a.m. with DON B revealed that he was notified on the 10/29/25 medication error for resident 1 by ADON C, and he asked ADON C to complete the investigation and follow-up. He did not review the FRI report before it was submitted to the SD DOH, but he thought the investigation was adequate. He stated that CMA D was immediately removed from administering medications and ADON C met with her to get her report on the event.</p> <p>CMA D was required to complete a 4-hour competency review with ADON C accompanying her as she administered medications and successfully completed the South Dakota Board of Nursing Medication Administration Clinical Skills Checklist on 11/4/25. CMA D was then allowed to return to medication aide duties. CMA D was now primarily scheduled to work on the long term care nursing home areas. He explained that during the investigation, they learned that a cultural aspect made it difficult for CMA D to ask people who they were, so they felt it would be better for her to be assigned to the long term care nursing home units because there was less resident turnover than the rehabilitation unit.</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>435127   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>11/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Dow Rummel Village   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>DON B agreed that the 10/29/25 medication error was a high-risk event and a significant medication error. When asked how all residents were protected, he responded by saying that making sure CMAs aides had an understanding of the correct [medication administration] process. He felt the CMAs did understand that process when they implemented a primary medication aide model in July and extensively interviewed the CMAs to determine their medication administration competency. Because they had done that and were in the process of incorporating additional annual training before the 10/29/25 incident, they did not provide any medication administration education with any staff other than CMA D after that incident. He stated that ADON C had talked to the nurses at the shift-to-shift report, but he did not have any expectations of the charge nurses to monitor medication administration.</p> <p>They had not completed any formal medication administration audits. He said ADON C had talked to some of the CMAs but did not document those conversations or who they were with. The annual online medication administration training was assigned to the CMAs on 11/11/25 with a 30-day completion requirement. They had not considered assigning the education to licensed nursing staff as well.</p> <p>14. Review of the provider's nursing staff schedule from 10/29/25 to 11/6/25 revealed that CMA D was removed from the CMA schedule on 10/29/25. She was transferred to work as a certified nursing assistant (CNA). She continued to work as a CNA on 10/30/25, 10/31/25, 11/1/25, and 11/3/25. She was reassigned as the medication aide on the morning of 11/4/25, where ADON C was paired with her from 6:00 a.m. to 10:00 a.m. She continued working as a CNA for the rest of her shift on 11/4/25, 11/5/25, and 11/6/25. From 11/8/25 to the current schedule at the time of the survey, she was scheduled in both the CMA and CNA roles.</p> <p>15. Review of the provider's January 2025 Abuse Prevention, Intervention, Reporting, and Investigation policy revealed appropriate steps were taken for investigation and reporting. The policy contained no directions for staff education or follow-up monitoring.</p> <p>16. Review of the provider's medication administration policy revised November 2025 revealed that the purpose was to ensure safe, accurate, and documented administration of medications and treatments to residents within our facility. By establishing clear procedures for medication administration records (MARS) and treatment administration records (TARs), this policy aims to safeguard against errors and ensure compliance with physician orders.</p> <p>The oral administration of medications procedure listed steps including Identify resident, and Administer the medication to the resident utilizing the 6 rights that include[d] Right Drug, Right Dose, Right Route, Right Time, and Right Resident and Right Documentation.</p> |  |  |