STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435127	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dow Rummel Village	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.Findings include: 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 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.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. 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.2. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. 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).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.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 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.A 4/16/26 nurses' progress note revealed that on 4/16/26 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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.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.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.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. 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 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.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.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.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.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 any new interventions were needed to be implemented to prevent further falls for those residents.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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1's scoop mattress was implemented on 4/20/26.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.6. CMA D was no longer employed by the provider at the time of the survey and was unavailable for interview.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.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.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.