STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOW RUMMEL VILLAGE	1321 W DOW RUMMEL ST , SIOUX FALLS, South Dakota, 57104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/6/26 through 1/8/26. Dow Rummel Village was found not in compliance with the following requirements F812, F880, and F921.	F0000		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure the staff followed food safety standards to ensure:*Open perishable food items were discarded once they had surpassed the five-day shelf life according to their policy in one of one walk-in cooler.*Ventilation covers were on a cleaning schedule and maintained to prevent	F0812	On 01/06/26, outdated food items were identified in the Main Kitchen walk-in cooler, including American cheese, fruit cocktail, and strawberries with visible mold. On the same date, ventilation covers in the Main Kitchen were observed with dust accumulation and positioned to blow air toward food preparation surfaces. All identified food items were removed and discarded on 01/06/26. Upon identification, the affected ventilation covers were removed, cleaned, and reinstalled angled away from food preparation areas. All remaining kitchen ceiling and air vents were cleaned. Effective 01/27/26, the facility revised weekly cleaning and monitoring assignments for the Main Kitchen walk-in cooler to include verification of food item dates during assigned shifts. The PM Cook is responsible each Saturday, and the AM Cook is responsible each Wednesday. Weekly cleaning of kitchen ventilation covers was added to the cleaning schedule. Completion of tasks is documented on cleaning logs. Staff education related to the Cleaning and Sanitation of Dining and Food Service policy was completed by 02/22/26.	02/22/2026

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F0812 SS = E	Continued from page 1 dust and lint buildup from circulating over food preparation and cooking surfaces in one of one main kitchen. Findings include: 1. Observation and interview on 1/6/26 at 9:00 a.m. in the main kitchen with culinary licensed supervisor (CLS) M revealed:*A sign on the walk-in cooler door stated:-"Shelf Life."-"Leftovers 5 days."-"ready to eat 5 days."-"Raw foods (after thawed) 5 days."*Inside the walk-in cooler on separate shelves there was:-An open package of American cheese slices wrapped in cling wrap dated with a hand written date of 12/20.-An opened plastic container of fruit cocktail dated 12/03.-Three flats of fresh strawberries dated 12/31/25.--Eight of those containers of strawberries had mold growing on the strawberries.*In the main kitchen four vents had heavy dust built up on the edges of the vents.*The vents were blowing air towards a food preparation (prep) table and the stove top.*CLS M stated that: -There was a 5-day open package policy for leftover foods.-The American Cheese should have been discarded.-She thought the fruit cocktail was mislabeled and should have been 1/03 and not 12/03 but could not prove that.*CLS M confirmed some of the strawberries had mold on them and should have been thrown out.*She agreed the vent covers had dust on them and should have been cleaned because they were blowing air over the food prep table and stove top.*She stated the dietary department staff were to clean food service areas according to weekly cleaning schedules.*She was unsure who was responsible for cleaning the vent covers. 2. Observation of the main kitchen and walk-in cooler on 1/7/26 at 11:19 a.m. revealed:*The American cheese, fruit cocktail, and strawberries had been removed from the walk-in cooler.*The vent covers remained in the same condition observed above with dust and lint on them. 3. Interview on 1/7/26 at 11:26 a.m. with director of building services (DOBS) N regarding the vent covers in the main kitchen revealed he:*Agreed there was dust and lint built up on the vent covers.*Thought the dietary department staff cleaned them.*Confirmed those vent covers were not part of the contracted oven hood cleaning service that was completed twice a year. 4. Interview on 1/8/26 at 11:34 a.m. with certified dietary manager (CDM) K and director of culinary services (DOCS) L revealed they:*Expected staff to remove expired and past use by date food items from the walk-in cooler.*Agreed the cheese slices, fruit cocktail, and strawberries should have been discarded.*Confirmed the vent covers in the kitchen were not on a cleaning schedule. 5. Review of the dietary department's weekly cleaning assignments confirmed the vent covers were not included on the cleaning schedule. 6. Review of the provider's 2013	F0812	Continued from page 1 The Director of Culinary Services or designee will audit walk-in cooler cleaning logs, food item dating, and kitchen ventilation cleanliness weekly for four (4) weeks, then monthly for two (2) months. Monitoring results will be reviewed through the QAPI process, and the QAPI Committee will determine when continued monitoring is no longer necessary based on sustained compliance.	

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F0812 SS = E	Continued from page 2 Food Safety and Sanitation policy revealed:*"Perishable ingredients are refrigerated when they are not being used."*"All time and temperature controls for safety (TCS) leftovers are labeled, covered and dated when stored. They are used within 72 hours (or discarded)."*"Note: ServSafe guidelines allow 7 days for food safety with the day of preparation counted as day 1 of the 7 days, and then food is discarded. Check your local and state regulations and determine which guidelines your facility will follow."*"Foods with expiration dates are used prior to the use by date on the package." 7. Review of the provider's 2013 Cleaning and Sanitation of Dining and Food Service Areas policy revealed:*"The food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule."	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	All staff received education related to infection prevention and control practices by 02/22/26. Education included, but was not limited to, cleaning and storage of shared use equipment, proper storage of oxygen and nebulizer tubing, handling and disposal of soiled items, and appropriate storage and use of reusable patient care items. Applicable infection prevention and control policies and procedures were reviewed and revised, as indicated, prior to staff education. Items identified as no longer appropriate for use were removed from service and discarded.	02/22/2026

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F0880 SS = E	Continued from page 3 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and policy review, the facility failed to ensure the staff followed infection prevention standards to prevent the spread of infection. * One of two rooms had mechanical lift slings touching	F0880	Continued from page 3 The Infection Prevention Nurse or designee will audit areas of concern for staff compliance with infection prevention practices twice weekly for one (1) month, weekly for one (1) month, every other week for one (1) month, and then monthly for four (4) months. Monitoring results will be reviewed through the QAPI process, and the QAPI Committee will determine when continued monitoring is no longer necessary based on sustained compliance.	

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F0880 SS = E	Continued from page 4 the floor when not in use. * One of four dirty linen rooms had used incontinent brief dispose of improperly. * Six of seven dirty linen and trash can lids on west hall were left open. * One of two nebulizer (a device that converts liquid medication into an inhalable mist) tubing observed lying on the floor in a resident's 5 room. * One of one whirlpool (heated pool in which hot water is continuously circulated) belt was touching the floor when not in use. * Two of four EZ stands (mechanical lift device) were improperly cleaned or disinfected after use. * One of four clean linen rooms had linens stored improperly. Findings Include: 1. Observation on 1/6/26 at 9:03 a.m. in the west hall in the PPE (Personal Protective Equipment) storage room revealed five slings were hanging from hooks and touching the floor. 2. Observation on 1/6/26 at 9:05 a.m. in the west hall dirty hopper (a specialized sink flushing device used to rinse soiled items and linens of body fluids) room revealed: *There was a used incontinent brief sitting on top of the trash can lid. *Total of three trash bin lids were left open. 3. Observation on 1/6/26 at 9:10 a.m. in resident 5's room revealed nebulizer (a device that converts liquid medication into an inhalable mist) tubing was lying on the floor behind the resident's chair.	F0880		

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F0880 SS = E	Continued from page 5 4. Observation on 1/6/26 at 9:16 a.m. in the west hall Whirlpool room revealed: * The whirlpool (heated pool in which hot water is continuously circulated) tub seat belt was hanging from the whirlpool and touching the floor. * Total of three dirty linen and trash bin lids were left open. 5. Observation on 1/6/26 at 11:02 a.m. in the west hall revealed an EZ stand (a mechanical lift used to assist from a seated to a standing position) or (a mechanical lift and sling used to lift a person's full body) had food debris on the footplate. 6. Interview on 01/06/2026 11:04 a.m. with certified medication aide (CMA) J revealed: *The EZ stand is to be cleaned after each resident and that would include the knee pad, footplate and arms of the machine. *The whirlpool tub belt should not touch the floor. 7. Observation on 1/6/26 at 11:13 a.m. in the north hall clean linen storage room revealed clean privacy curtains were spilling out of a broken cardboard box onto the floor. 8. Observation on 1/8/26 at 11:45 a.m. in the west hall was an EZ stand noted to have food debris on the footplate. 10. Observation on 1/8/26 at 11:47 a.m. in the north hall was an EZ stand noted to have food debris on the footplate. 11. Interview on 1/8/26 at 11:36 a.m. with CMA I revealed: *Soiled incontinent briefs were to be placed in a trash bag. That bag should be closed and then placed in the garbage bin in the hopper room. *Oxygen and nebulizer tubing should not be touching the floor.	F0880		

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F0880 SS = E	Continued from page 6 *Catheter urine collection bags should be covered at all times for dignity and infection reasons. *She agreed that mechanical lift slings are not clean when touching the floor. 12. Interview on 1/8/26 at 12:29 p.m. with assistant director of nursing (ADON)/infection preventionist (IP) C revealed: *Incontinence briefs should be placed in a garbage bag and disposed of by placing the incontinence brief in a closed bag and then placing it in a trash bin. *Oxygen tubing and nebulizer tubing should not touch the floor. *She agreed that mechanical lift straps should not touch the floor. *EZ stands were to be cleaned after each resident's use. 13. Review of the providers 3/5/13 Restorative Equipment Cleaning policy revealed: *"It shall be the policy of Dow Rummel Village that all restorative equipment and supplies that are used for more than one resident be cleaned and sanitized in between each resident use." * "Following resident use of any equipment or supplies, cleaning and disinfecting must be done before the same piece of equipment may be utilized by another resident." 14. Review of the providers 10/4/13 Disposal of Incontinence Products policy revealed: *"To ensure a safe environment Dow Rummel Village has established guidelines for managing and disposing of incontinence products. Incontinence products may include but not limited to disposable diapers (briefs), incontinence pads, panty shield products, sanitary pads, tampons and/or disposable wipes. If appropriate should use reusable products. When disposable items are used, emphasis should be placed upon the use of biodegradable items." - "2. The disposable incontinence products should be placed in a waste receptacle that will be located in	F0880		

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F0880 SS = E	Continued from page 7 the bathroom or toilet area." -"4. If the waste is non-hazardous, and appropriately bagged and sealed, it can be disposed of with normal waste products (regular garbage containers)." 15. Review of the providers' November 2023 revised Laundry and Linens policy revealed: *"Any clean items that come in contact with soiled items or soiled PPE will be considered contaminated." *"All clean laundry and linens will be handled in a manner that prevents contamination." 16. Review of the providers' April 2024 revised Infection Control & Prevention policy revealed: *"To provide a safer and healthier community through the prevention of infection." *"9. Maintain equipment in safe and sanitary condition." *"b. Follow policy for garbage and laundry handing." *"c. How and when to use standard precautions, including proper hand hygiene practices and environmental cleaning and disinfection practices." *"f. Proper infection prevention and control practices when performing resident care activities as it pertains to staff roles, responsibilities and situations."	F0880		
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review the provider failed to ensure chemicals were stored safely away from resident' for: *One of one beauty shop.	F0921	On 01/06/26, chemicals were identified stored in unsecured locations accessible to residents in the beauty salon and utility areas.	02/22/2026

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F0921 SS = E	Continued from page 8 *One of four hopper rooms. *One of four eye-wash rooms. Findings include: 1. Observation on 1/6/26 at 9:16 a.m. of the beauty shop in the west hall revealed: *The room was unattended, and the door was unlocked. *A half bottle of Barbicide (disinfectant concentrate) was sitting on the counter by the sink. *A opened box of Ship shape powder (a multi-purpose cleaning powder) was sitting on counter by sink. *The door was to be locked when not in use. *Several residents are sitting outside the beauty shop watching tv currently. 2. Observation on 1/6/26 at 10:51 a.m. of east hall hopper room revealed: *The door was not locked. *A unlocked cupboard had signage on it that said the cupboard was to be always locked. *That unlocked cupboard had one container of Foamy Q & A acid disinfectant cleaner, one Consume odor eliminator (cleaner used to breakdown organic waste such as urine and feces) bottle, one Difference multipurpose cleaner bottle, and one Lysol disinfectant spray bottle inside of it. *Several residents walk by the door on the way to dining room for meals. 3. Interview on 1/6/26 at 9:41 a.m. with registered nurse (RN) D revealed the beautician was at the facility two to three times a week. RN D was unsure if the beauty shop door should be locked. 4. Interview on 1/6/26 at 9:42 a.m. with assistant director of nursing (ADON)/infection preventionist (IP) C revealed:	F0921	Continued from page 8 Upon identification, chemicals were secured and access was restricted. In collaboration with the Director of Building Services, cabinet locking mechanisms were replaced or repaired as needed to ensure chemicals could be secured appropriately. Housekeeping carts containing chemicals are required to remain locked when not in the direct presence of staff, and the beauty salon remains locked when not in use. All applicable policies and procedures related to chemical storage and environmental safety were reviewed and updated by 02/22/26. Staff education related to safe chemical storage practices was completed by 02/22/26. The Director of Nursing or designee will audit chemical storage areas weekly for four (4) weeks, then monthly for two (2) months. Monitoring results will be reviewed through the QAPI process, and the QAPI Committee will determine when continued monitoring is no longer necessary based on sustained compliance.	02/22/2026

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F0921 SS = E	Continued from page 9 *The beauty shop door should be locked when no one is in it. *She agreed that the chemicals were sitting on the counter and not locked up and should have been. 5. Interview on 1/6/26 at 10:56 a.m. with housekeeper O revealed: *Housekeeping carts were to be locked when unattended or not in use. *The cupboard in the east hall hopper room was supposed to always be locked. *The cupboard was not locked because the key was bent. *When asked who she notified when something was broken she stated, she would notify ADON/IP C it was not lockable and the key was broken. 6. Follow-up interview on 1/6/26 at 11:00 a.m. with assistant director of nursing (ADON)/infection preventionist (IP) C revealed: *The outside door to the east hall hopper room door was never locked. *The cupboard inside the room where chemicals were stored was to always be locked. *She was unable to get the lock to work. 7. Observation on 1/6/26 at 11:14 a.m. of north hall eye-wash room revealed: *The door was unlocked and a housekeeping cart was inside that room. *That housekeeping cart was unlocked and contained: -A bottle of BNC 15 (a disinfectant). -A bottle of Sparkling glass cleaner. -A spray bottle labeled with 50% bleach [50 percent] and 50% water. -On bottle of Difference brand multipurpose cleaner. -One bottle of Damp mop cleaner.	F0921		

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F0921 SS = E	Continued from page 10 -A bottle of Clean by Peroxy (hydrogen peroxide-based all-purpose cleaner). *A bottle of Bona hardwood floor cleaner was sitting on a shelf inside that room. 8. Observation on 1/8/26 at 8:24 a.m. north hall eye-wash room revealed: *The door was unlocked. *The housekeeping cart was still inside, was unlocked and contained the same chemicals as observed on 1/6/26. *Residents pass the room on the way to the dining room. 9. Review of the provider's revised October 2024 Cleaning policy revealed: *"To provide a safe, clean, comfortable and homelike environment. -Chemicals on carts must be locked up when the cart is not visible to housekeepers and/or nursing staff at all times. -Carts must be stored in a locked room." 10. Review of the provider's 3/5/13 Restorative Equipment Cleaning Policy revealed "Sanitizers and disinfectants will be kept in a secure area out of resident reach and locked up whenever staff is not in attendance."	F0921		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 1/6/26. Facility Dow Rummel Village was found in compliance.	E0000		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christopher Hahn	Administrator of Health Care Services	02/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALLEN WING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOW RUMMEL VILLAGE	1321 W DOW RUMMEL ST , SIOUX FALLS, South Dakota, 57104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A recertification survey was conducted on 1/6/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Dow Rummel Village was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K355 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0355 SS = E Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to perform monthly checks of fire extinguishers in accordance with NFPA 10 on three randomly checked fire extinguishers (108, 109, and 110) since the annual inspection. Findings include: 1. Observation on 1/6/26 at 12:45 p.m. revealed fire extinguisher #108 did not have monthly maintenance checks written on the fire extinguisher tag since its annual inspection in June of 2025. Interview with the manager of building service at the time of the observation revealed he was unaware that condition existed for that fire extinguisher. He stated the maintenance technician who performed all the maintenance on those devices had recently been terminated.	K0355	On 01/06/26, fire extinguishers #108, #109, and #110 were reviewed by Building Services after it was identified that monthly inspection documentation had not been completed since their annual inspection in June 2025. All required monthly inspection checks were completed and documented on the fire extinguisher tags in accordance with NFPA 10 requirements. All fire extinguishers were verified to be present, fully charged, and operable. An audit of all portable fire extinguishers throughout the Skilled Nursing Facility was conducted to verify monthly inspection documentation was current and complete. Any missing or incomplete monthly inspection documentation identified during the audit was corrected to ensure compliance with NFPA 10 requirements.	02/22/2026

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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K0355 SS = E Bldg. 01	Continued from page 1 2. Observation on 1/6/26 at 1:02 p.m. revealed fire extinguisher #109 did not have monthly maintenance checks written on the fire extinguisher tag since its annual inspection in June of 2025. Interview with the manager of building service at the time of the observation revealed he was unaware that condition existed for that fire extinguisher. He stated the maintenance technician who performed all the maintenance on those devices had recently been terminated. 3. Observation on 1/6/26 at 1:15 p.m. revealed fire extinguisher #110 did not have monthly maintenance checks written on the fire extinguisher tag since its annual inspection in June of 2025. Interview with the manager of building service at the time of the observation revealed he was unaware that condition existed for that fire extinguisher. He stated the maintenance technician who performed all the maintenance on those devices had recently been terminated. Further interview with manager of building services later that same day revealed the facility recently changed their preventative maintenance system and the zone for the nursing home did not get loaded into that system. The deficiency had the potential to affect 100% of the building occupants.	K0355	The facility reviewed its Work Order Management system and identified that during a system transition, the Skilled Nursing Facility monthly fire extinguisher inspection zone was not fully incorporated as an automatically recurring work order. This issue was corrected to ensure all required zones are fully loaded and recurring monthly inspection work orders are generated. To ensure sustained compliance, the Director of Building Services or designee will conduct random monthly audits of fire extinguisher inspection documentation for three (3) months. Monitoring results will be reviewed through the QAPI process, and the QAPI Committee will determine when continued monitoring is no longer necessary based on sustained compliance.	02/22/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10678	A. BUILDING: _____ B. WING _____	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOW RUMMEL VILLAGE	1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/6/26 through 1/8/26. Dow Rummel Village was found not in compliance with the following requirement: S157 and S169.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation for one entire corridor (east wing). Findings include: 1. Observation and testing at 12:14 p.m. on 1/6/26 revealed the exhaust ventilation in the bathroom of resident room 762 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the manager of building services at the time of the above observation confirmed that finding. He revealed he was unaware why the exhaust ventilation was not working at that location. He further stated the rooftop exhaust fan serving that room also served all other rooms in the east wing. Further testing of additional rooms 761, and 768 confirmed that statement.	S 157	S157 – Ventilation On 01/06/26, the Building Services Department investigated non-functioning exhaust ventilation serving the East Hall corridor, including resident rooms 761, 762, and 768. The rooftop exhaust fan serving the East Hall was found to be intermittently inoperable due to a failing motor. A licensed HVAC contractor was contacted on 01/07/26 to verify the motor failure. Upon receipt of estimates from two licensed vendors, a replacement unit was ordered on 01/14/26. The unit is built to order with a projected delivery date of 02/06/26 and a scheduled installation date of 02/09/26. Upon completion of installation, exhaust ventilation will be retested in all East Hall resident rooms. The facility maintains a preventive maintenance program for exhaust ventilation systems, which includes bi-annual inspection and operational testing of rooftop exhaust fans, documentation of inspections and corrective actions, and referral to a licensed HVAC contractor when deficiencies are identified. The most recent inspection and testing was completed on 10/22/25, with no deficiencies identified at that time.	02/22/2026

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S 157	Continued From page 1 Further interview with manager of building services later that same day revealed the motor for the exhaust serving those rooms was "tripping out" and would need to be replaced.	S 157	To ensure sustained compliance, the Director of Building Services or designee will review ventilation preventive maintenance logs quarterly to verify inspections are completed as scheduled. Random airflow testing will be conducted monthly in resident bathrooms and other required areas. Any deficiencies identified will be corrected and documented. Monitoring results will be reported to the QAPI Committee. The QAPI Committee will determine when continued reporting of audit results is no longer necessary based on sustained compliance.	
S 169	44:73:02:18(5-7) Occupant Protection The facility shall: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically-activated audible alarm on all unattended exit doors. Any other exterior doors must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence when the door is closed; (7) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in the facility; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and testing, the provider failed to ensure an audible alarm for one randomly observed unattended exit door to the exterior (ambulance exit door). Findings include: 1. Observation and testing at 12:45 p.m. on 1/6/26 revealed the ambulance exit door (south of the old nurse station) was equipped with a door alarm but it did not sound when the door was opened. Further observation and testing at that	S 169	S169 – Occupant Protection On 01/06/26, upon identification that the ambulance exit door alarm was disabled, the alarm was immediately reactivated to ensure it sounded when the door was opened and was audible at the designated staff station.	02/22/2026

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S 169	Continued From page 2 same time revealed that doors alarm had been disabled (turned off) at the alarm panel. Interview with the manager of building services at the time of that observation revealed he was not aware of that alarm had been disabled.	S 169	Following the immediate correction, the Director of Building Services conducted a review of all exit doors in the Skilled Nursing Facility to verify alarms were activated and functioning as intended. The facility maintains a Door Alarm Policy and a scheduled monthly door alarm testing process through an automated maintenance work order. Monthly testing is completed by the maintenance team, the Director of Nursing, or the Director of Building Services. Review of the prior year of testing confirmed routine door alarm testing was completed as scheduled. A follow-up test of the ambulance exit door alarm was conducted on 01/09/26 with no deficiencies identified. To ensure sustained compliance, the Director of Building Services or designee will conduct focused monitoring of the ambulance entrance door alarm four (4) times per week for four (4) weeks, three (3) times per week for three (3) weeks, two (2) times per week for two (2) weeks, and then monthly through the recurring Skilled Nursing Facility door alarm testing work order. Monitoring results will be reported to the QAPI Committee. The QAPI Committee will determine when continued reporting of audit results is no longer necessary based on sustained compliance.	02/22/2026