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
	69060	A. BUILDING: _____ B. WING _____	C 09/11/2025

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 Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 9/9/25 through 9/11/25. Areas surveyed included quality of care, restratints, and resident safety related to resident elopement (leaving the facility without staff knowledge). Dow Rummel Village was found not in compliance with the following requirements. S030 and S838	S 000		
S 030	44:70:01:07 Reports To The Department Each facility shall report the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation for the event and report the results to the department no later than five working days after the event. The department may request additional information from the facility and investigate any	S 030	The facility has reviewed and clarified internal processes for mandatory reporting. On October 22, 2025, the Administrator and/or Director of Nursing will provide formal re-education to all nursing staff on the appropriate way to communicate suspicion of abuse or neglect to leadership. This training will emphasize that all concerns must be reported immediately to a charge nurse, Resident Care Coordinator, the DON, or the Administrator, and that these concerns must be documented and investigated in accordance with policy. The Administrator and DON reviewed expectations with leadership staff and Charge Nurses to ensure that any allegation or suspicion of abuse is reported to the South Dakota Department of Health within appropriate timeframes and that the results of the investigation are submitted within 5 working days.	10/26/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christopher Hahn
TITLE: Administrator of Health Care Services
(X6) DATE: 10/3/25

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S 030	Continued From page 1 reported event. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review the facility failed to report to the department of health that one of one sampled resident (1) had been slapped on the hand by certified nurse assistant (CNA) E that had been witnessed by her spouse resident 2 who resided upstairs in the independent living unit. Findings include: 1. Interview on 9/10/25 at 3:43 p.m. with resident care coordinator (RCC) C revealed: *She was aware of one incident that occurred within the last two weeks of a staff member who had hit a resident on the hand. She had been informed of that incident and reported to her supervisor administrator A. *She stated that incident had been reported to a nurse by resident 1's husband. *She was not sure if that incident had been reported to south dakota department of health (SD DOH). She knew that CNA E employment at the facility had been terminated for that incident. *RC C stated that she had not had or heard of any other complaints regarding CNA E, but stated CNA E's approach was not not appropriate or what she would call the "buddy's approach" because she had, "A language barrier and broken English." 2. Interview on 9/11/25 at 12:00 p.m. with administrator A revealed: *He stated he did not have any information regarding resident 1 having been hit by a staff member.	S 030	The Social Worker, DON and Resident Care Coordinators will meet weekly to review all incident reports and will audit weekly for 4 weeks. They will then audit monthly for 2 months. Results of these audits will be reviewed in QAPI and additional corrective action taken as needed.	10/26/25

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S 030	Continued From page 2 *He was not aware of that incident, but was aware of a personnel issue with CNA E, and stated her employment had been terminated. *He did not investigate or report that incident because he was not aware of it. 3. Interview on 9/11/25 at 10:29 a.m. with resident 1's spouse revealed: *He was resident 1's husband and who lived in a nearby independent living and would visit his wife, who resided in the memory care area. *He stated his wife had dementia and they could not live together because she needed more care then he did. *He stated, "A couple to three weeks ago my wife had been talking about this CNA that was not very nice." He had been visiting his wife (resident 1) the previous week. During that visit he witnessed the CNA [identified as CNA E] trying to get resident 1 to walk with her. CNA E was slapping resident 1's hands, which he thought she was doing to try to get his wife to take the CNA's hand to lead her ." *He stated when CNA E slapped his wife's hands, his wife slapped CNA E across her face, "It was hard, and it was loud." *He stated he had told a staff member, but could not remember who, about that incident but had not reported that he had heard that same CNA being loud and yelling at other residents. *He stated, "I could understand she [CNA E] wasn't from here and had a language barrier and that wasn't her fault, but it was her fault she did not know how to work with these residents." *He stated resident 1 did not have any injuries or red marks on her hands that would have resulted from that incident. 4. Review of CNA E's record revealed. *Her last day of employment at the facility was on	S 030		

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S 030	Continued From page 3 9/9/25. *She had been had been short and abrasive to residents. 5. Review of resident 2's electronic medical record (EMR) revealed: *She had a diagnosis of dementia (a group of symptoms affecting memory, thinking, and social abilities). *A 9/2/25 progress note written by registered nurse (RN) D indicated resident 1's spouse had witnessed his wife resident 1, had been slapped by a certified nurse assistant (CNA) the previous week and resident 1 had slapped the CNA back. *RN D had sent a message to administrator A, director of nursing (DON) B, and the staff scheduler. That note did not indicate the who the CNA was and that the incident had been reported to the SD DOH. 6. Review of the provider's January 2025 Abuse Prevention, Intervention, Reporting and Investigation policy revealed: *"Dow Rummel Village (DRV) has developed a system for identifying, investigating, preventing, and reporting any incident or suspected incident of any type of abuse." *"It is the responsibility of all staff to promptly report to facility management any incident or suspected incident of neglect or resident abuse from other residents, staff, family, or visitors including injuries of an unknown source, theft, or misappropriation of resident property." *"DRV staff are state mandated reporters, "Covered Individuals" (per Elder Justice Act), and must comply with state regulations regarding reporting suspected abuse and with federal regulations regarding reporting any reasonable suspicion of a crime against a resident or other individual receiving care by DRV."	S 030		

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S 030	Continued From page 4 *All reports of resident verbal, sexual, physical, and metal abuse: corporal punishment: involuntary seclusion: neglect: or misappropriation of resident property DRV will promptly and thoroughly investigate."	S 030		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review and policy review, the facility failed to ensure one of one sampled resident (1) was provided quality of care, free of abuse by certified nursing assistant (CNA) E who slapped resident 1's hand. That incident had been witnessed by resident 1's spouse. Findings include: 1. Interviews, record reviews, and policy review during the survey on 9/9/25 through 9/11/25 regarding resdient 1 revealed: The incident of a staff member slapping a resdient was potential abuse. -That potental abuse event had not been investigated and reported according to the provider's policy.	S 838	The CNA involved in this incident was terminated on September 5, 2025, due to performance issues and inability to communicate effectively with staff and residents. Resident #1 was assessed following the event and no injuries were identified. Staff working in the affected area were reminded of Dow Rummel's zero-tolerance policy for abuse. On October 22, 2025, the Administrator and/or Director of Nursing will provide formal re-education to all staff in the affected area on resident rights, the facility's zero-tolerance policy for abuse, and dementia-specific communication strategies, including the Buddies Forever approach. This training will reinforce that all residents must be treated with dignity and respect and remain free from any form of abuse or neglect. Documentation of training attendance will be maintained on file. The Director of Nursing or designee will conduct random weekly observations of staff/resident interactions for three months, transitioning to monthly for three additional months. Any concerns will be addressed immediately. Audit results will be presented to QAPI for ongoing monitoring.	10/26/2025

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S 838	Continued From page 5 Refere to S030.	S 838		