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
	41884	A. BUILDING: _____ B. WING _____	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYBREAK VILLAGE, INC	956 E 7TH ST WINNER, SD 57580

(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) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 5/4/26 through 5/5/26. Daybreak Village, Inc was found not in compliance with the following requirements: S105, S165, S201, S295, S305, S330, S506, and S775. 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 5/4/26 through 5/5/26. The area surveyed included a resident elopement. Daybreak Village, Inc was found in compliance.	S 000		
S 105	44:70:02:06 Food Service Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to prevent cross-contamination of fully cooked food from raw meat in the kitchen refrigerator. Findings include:	S 105	Plan of Correction - 44:70:02:06 Food Service The facility submits the following Plan of Correction in response to the citation regarding failure to prevent cross-contamination of fully cooked food from raw meat. Corrective Action Taken: Any fully cooked pork and ham potentially exposed to raw meat juices were immediateluy washed and seperated. The refrigerator pan and shelving were cleaned and sanitized. Raw hamburger was relocated to a seperate leak-proof container. Cook D received immediate retraining on proper food storage hierarchy and safe thawing procedures. A full inspection of all refrigerators, freezers, and dry storage was completed to ensure no additional cross-contamination risks were present. Systemic Changes Implemented: The facility updated its Dietary Policies to include a revised thawing and storage procedure/reminder requiring raw meat to be stored only on the bottom shelf in sealed containers. A visual storage hierarchy chart has been posted in all cold-storage areas. All dietary staff will completed mandatory retraining on cross-contamination prevention, with the content added to new-hire orientation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 6-8-2026

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S 105	Continued From page 1 1. Observation on 5/4/26 at 4:00 p.m. in the kitchen refrigerator revealed that two (ten pound) logs of raw hamburger were placed on top of one (five pound) package of fully cooked pork and two (two and a half pound) packages of sliced fully cooked ham, all in the same pan. The hamburger was raw and was starting to thaw. Blood was leaking from the packages of hamburger into the pan where the fully cooked pork and ham were stored. 2. Interview on 5/4/26 at 4:05 p.m. with cook D revealed he had pulled the hamburger, pork, and ham from the freezer and placed them in the pan in the refrigerator to thaw. He was not aware that raw hamburger should be stored separately from fully cooked foods to prevent cross contamination.	S 105	Monitoring to Ensure Ongoing Compliance: The kitchen staff will be instructed and quizzed on all safety practices to ensure cross-contamination does not occur. The Administrator and Kitchen Manager will conduct monthly dietary audits for six months to ensure compliance. All monitoring results will be reviewed during the monthly Quality Assurance Committee meeting, with corrective action taken immediately if noncomplinace is identified. Anticipated Date of Correction: May 25. 2026	5/25/26
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on testing, interview, and record review, the provider failed to test the emergency lights monthly. Findings include:	S 165	Plan of Correction - 44:70:02:17 Occupant Protection The facility submits the following Plan of Correction in response to the citation regarding failure to test emergency lights monthly. Correction Action Taken: The emergency lights that failed testing on 5/4/26 were immediately repaired and relaced to ensure full illumination during power loss. All emergency lights in the facilty were tested, and any additional deficiencies were corrected. The Director of Maintenance receieved immediate retraining on monthly emergency-light testing requirements and documentation standards. The monthly preventative maintenace checklist was updated to include emergency-light testing as a required task. Sytemic Changes Implemented: The facility revised its Maintenance Policy to ensure inclusion of a testing check off which requires monthly functional testing of all exit and emergency lights, with documentation retained for surveyor review. The Director of Maintenance and Administrator reviewed the updated checklist together to ensure full understanding of responsibilities and regulatory expectations.	

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S 165	Continued From page 2 1. Testing of the exit lights/emergency lights on 5/4/26 from 3:00 p.m. to 5:00 p.m. revealed the emergency light by room 119 would not illuminate when tested. The exit light/emergency light above the exit located by room 135 would not illuminate when tested. The exit light/emergency light located above the smoke barrier doors by room 132 would illuminate but not to its full capacity. 2. Review of the monthly maintenance records revealed that the emergency lights were not on the monthly preventative maintenance activities. 3. Interview with the director of maintenance E on 5/5/26 at 1:00 p.m. revealed he was not testing the emergency lights.	S 165	New batteries were placed in all signs to ensure proper updating. Monitoring to Ensure Ongoing Compliance: The Director of Maintenance will complete and document monthly emergency-light testing moving forward. The Administrator will ensure review and sign off on the monthly logs going forward to verify accuracy and completion. Monthly, the Administrator will audit emergency-light documentation and physical function of a sample of lights to ensure sustained compliance. All monitoring results will be reviewed during the monthly Quality Assurance Committee meeting, with corrective action implemented immediately if deficiencies were identified. Anticipated Date of Correction: May 19, 2026	5/19/26
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation and interview, the provider failed to maintain the self-closing feature for one of one door to the "breakroom." Findings include:	S 201	Plan of Correction - 44:70:03:02 General Fire Safety The facility submites the following Plan of Correction in response to the citation regarding failure to maintain required fire-safety protections, including a self-closing door in a hazardous area, required fire drills, and proper operation of smoke-barrier doors. Corrective Action Taken: The breakroom door was immediately reconnected and repaired to restore full self-closing functionality. The door wedge was removed, and the room was reassessed and confirmed to meet hazardous-area requirements. All smoke-barrier doors, including the set between the dining room and room 137, were inspected and adjusted to ensure proper alignment and full closure when released from magnetic hold-open devices. A complete review of fire drill records were conducted, and staff responsible for drills received immediate retraining on required frequency and shift coverage. Systemic Changes Implemented: The facility updated its Fire Safety Policy to include clear procedures for maintaining self-closing devices on hazardous-area doors and for verifying proper operation of smoke-barrier doors. A monthly door-inspection checklist has been added to the preventative maintenance program.	

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S 201	Continued From page 3 1. Observation on 5/4/26 at 2:38 p.m. of the breakroom revealed the room was larger than 100 square feet and contained electrical breaker boxes making it a hazardous area requiring a self-closing door. The door was open to the corridor and was held in the open position with a wooden wedge. The closing device for the door was disconnected. 2. Interview on 5/4/26 at 4:30 p.m. with the owner C and administrator A revealed that before the air conditioner was installed in the window of the breakroom the room would get uncomfortably hot. The door was wedged open to allow the heat to escape. The closing device was disconnected to make it easier to hold the door open. They did not consider the room a hazardous area and were not aware that the door was required to be self-closing to protect the corridor. B. Based on record review and interview, the provider failed to conduct monthly fire drills for nine of the last twelve months and conduct two fire drills during sleeping hours. Findings include: 1. Review of the fire drill records revealed there were four drills recorded in the last twelve months. Those four drills were all done during the day shift. There were no fire drills conducted during sleeping hours. 2. Interview on 5/5/26 at 11:30 a.m. with director of nursing B revealed she was aware they needed to conduct monthly fire drills alternating between the two shifts, and two fire drills were to be conducted during sleeping hours. The last year was "very chaotic," and she was unable to complete the drills.	S 201	The fire drill schedule has been revised to ensure monthly drills alternating between shifts, with two drills conducted during sleeping hours each year. Fire drill responsbilities have been reassigned to ensure coverage during periods of staff turnover or operational disruption. Monitoring to Ensure Ongoing Compliance: The Director of Mainteance will complete and document monthly inspections of all self-closing doors, smoke-barrier doors, and magnetic hold-open devices going forward since understanding of state requirements have been relayed. The Administrator will review and sign off on these inspections monthly. Fire drill logs will be reviewed by the Administrator and Director of Nursing each month to verify completion, shift rotation, and required sleeping-hour drills. All monitoring results will be presented to the Quality Assurance Committee at the monthly QA meeting for six months, with corrective action implemented immediately if deficiencies are identified. Anticipated Date of Completion: May 18, 2026	5/18/26

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S 201	Continued From page 4 3. Interview on 5/5/26 at 1:30 p.m. with administrator A revealed that he confirmed they were to conduct monthly fire drills alternating between the two shifts, and two fire drills were to be conducted during sleeping hours. C. Based on testing and interview, the provider failed to maintain the smoke barrier doors between the dining room and resident room 137. Findings include: 1. Testing of the smoke barrier doors on 5/4/26 at 3:50 p.m. located between the dining room and resident room 137 revealed the smoke barrier doors were held open by magnetic hold open devices that were connected to the fire alarm system. When the doors were released from the magnetic hold open devices, the doors attempted to close. The doors were unable to close because the timing of the doors closing was such that the north leaf of the door caught the magnet rod on the back side of the south door, which stopped the north leaf from closing. The north leaf stayed open about two inches. 2. Interview on 5/4/26 at 4:35 p.m. with administrator A and owner C revealed they were not aware that those doors were not closing correctly. Administrator A stated that those doors had closed correctly during the last fire drill on 4/23/26.	S 201		
S 295	44:70:04:04 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education	S 295	Plan of Correction - 44:70:04:04 Personnel Training The facilty submits the following Plan of Correction in response to the citation regarding failure to ensure completion of required annual training for one employee.	

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S 295	Continued From page 5 programs must cover the required subjects annually. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure one of five sampled employees (F) had completed the required annual training topics. Findings include: 1. Review of the personnel file for activity director F revealed that she was hired on 9/20/24. The initial required training was completed on 9/23/24. There was no documentation to support that activity director F had completed the annual required training in 2025 or during the first five months of 2026. 2. Interview on 5/5/26 at 4:30 p.m. with administrator A revealed that all employees were to complete training on all the required topics following their hire date and annually. The training was provided to the employees through the use of an educational video that covered the topics identified in the regulation. After the employee watched the video, he/she would complete a post-test. Administrator A acknowledged that there was no documentation to support that activity director F had completed any of the required training since September 2024. 3. A policy regarding annual personnel training was requested from administrator A on 5/5/26 at 4:30 p.m. but it was not provided by the end of the survey.	S 295	Corrective Action Taken: Activity Director F will complete all required annual training topics, including the post-test, and documentation was placed in her personnel file. All employee files were reviewed to ensure no additional staff were missing required annual training. No other deficiencies were identified. The Administrator provided immediate retraining to Activity Director F and the Director of Nursing on the requirment for annual completion and documentation of all mandated training topics. Systemic Changes Implemented: The facility updated the Annual Personnel Training Policy outlining related topics, timelines, and documentation standards called Educare. The facility's onboarding and annual review processes were updated to ensure required training is assigned, completed, and documented consistently. The Administrator and Director of Nursing will jointly oversee the annual training schedule to ensure compliance. All current staff will have renewed annual training, that has been assigned on Educare, to be completed the first week of July. Monitoring to Ensure Ongoing Compliance: The Administrator will review personnel files monthly for three months to verify that all requied annual training is completed and documented. After three months, quarterly audits will be conducted for the remainder of the year. Educare will complete an automatic reassignment of annual personnel training. Monitoring results will be reviewed during the monthly Quality Assurance Committee meeting, with corrective action taken immediately if any gaps are identified. Anticipated Date of Correction: June 3, 2026	6/3/26

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S 305	Continued From page 6	S 305	Plan of Correction - 44:70:04:05 Personnel Health Program	
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure three of five sampled employees (G, H, and I) were evaluated by a licensed health professional within 14 days from their hire date. Findings include: 1. Review of the personnel file for caregiver G revealed he was hired on 11/4/24. He had completed and signed his portion of the employee health record document on 11/4/24, but it was not reviewed and signed by a licensed health professional. 2. Review of the personnel file for registered medication aide (RMA) H revealed that she was hired on 2/16/25. She had completed and signed her portion of the employee health record document on 2/10/25, but it was not reviewed and signed by a licensed health professional. 3. Review of the personnel file for cook I revealed that she was hired on 1/22/26. She had completed and signed her portion of the employee health record document on 1/22/26, but it was not reviewed and signed by a licensed	S 305	The facility submits the following Plan of Correction in response to the citation regarding failure to ensure new employees were evaluated by a licensed health professional within 14 days of hire. Corrective Action Taken: Employees F, H, and I were immediately evaluated by the licensed health professional, and their employee health record forms were completed and signed. Documentation was placed in each personnel file. A full audit of all employee files was conducted to identify any additional missing health evaluations: no further deficiencies were found. The Administrator and RN/DON reviewed the regulatory requirement to ensure understanding of the 14-day completion timeline. Systemic Changes Implemented: The facility will ensure a signature is placed and Employee Health Screening Policy completed for each current and future employee. A standardized Employee Health Evaluation Form and tracking log have been added to the onboarding packet. The onboarding workflow was revised so that no employee may begin independent duties until the licensed health professional's evaluation and signtature is completed. Monitoring to Ensure Ongoing Compliance: The Administrator will review all new-hire files within 14 days of hire for three months to verify completion of the licensed health professional's evaluation. The RN/DON will maintain the master health-screening log updated with each new hire. After the initial three-month period, quarterly audits will be conducted for the remainder of the year. Monitoring results will be reviewed during the monthly Quality Assurance Committe meeting, and corrective action will be taken immediately if any noncompliance is identified. Anticipated Date of Correction: June 3, 2026	6/3/26

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S 305	Continued From page 7 health professional. 4. Interview on 5/5/26 at 4:30 p.m. with administrator A revealed registered nurse/director of nursing (RN/DON) B was the licensed health professional responsible for the completion of the employee health record form. He stated that they had made several changes to the onboarding processes recently, and believes that was why the licensed health professional's signature was not present on the employee health record documents. He acknowledged that the health of all new employees were to be evaluated by the licensed health professional upon hire, and for it be documented as completed with a signature. RN/DON B was not in the building for an interview at the time of the above interview with administrator A. 5. A policy regarding employee health screenings was requested from administrator A on 5/5/26 at 4:30 p.m., but it was not provided by the end of the survey.	S 305		
S 330	44:70:04:10 Tuberculin Screening... Requirements Each facility shall develop criteria to screen healthcare personnel and residents for Mycobacterium tuberculosis (TB) based on the Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. Each facility shall establish policies and procedures for conducting TB risk assessment that include the key components of responsibility, surveillance, and containment. The frequency of	S 330	Plan of Correction - 44:70:04:10 Tuberculin Screening Requirements The facility submits the following Plan of Correction in response to the citation regarding failure to complete an annual tuberculosis (TB) risk assesment for the facility. Corrective Action Taken: The facility's annual TB risk assessment was completed immediately using the CDC/NTCA 2019 guidelines. Documentation was finalized and placed in the facility's infection control file. The RN/DON received immediate education on the requirement for annual TB risk assessments and the regulatory expectations for documentation. All related policies were reviewed to ensure alignment with the current CDC recommendations.	

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S 330	Continued From page 8 repeat screening depends upon annual facility risk assessment results. Any resident identified as asymptomatic upon admission as short stay or anticipated stay of thirty days or less is not required to have a tuberculin skin test or a TB blood assay test. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and policy review, the provider failed to ensure an annual tuberculosis (TB) risk assessment was completed for the facility. Findings include: 1. On 5/4/26 at 2:30 p.m. this surveyor presented registered nurse/director of nursing (RN/DON) B with a list of requested documents which included the facility's annual TB risk assessment. 2. Interview on 5/5/26 at 10:58 a.m. with RN/DON B revealed she was not aware of the requirement for the completion of the annual TB risk assessment. She was the licensed nurse for the facility since September 2024. 3. Review of the provider's undated Tuberculosis Screening policy revealed that an annual TB risk assessment was to be completed by the facility but did not provide guidance regarding the process for its completion.	S 330	Systemic Changes Implemented: The faciltiy revised its Tuberculosis Screening Policy to include a clear, step-by-step process for completing the annual TB risk assessment, including responsible personnel, required components, and documentation standards. A standardized Annual TB Risk Assessment Form was created and added to the infection control program. The RN/DON was assigned responsibility for completing the assessment annually, with the Administrator designated as secondary reviewer. Monitoring to Ensure Ongoing Compliance: The Administrator will verify completion of the annual TB risk assessment each January and document the review for the next 12 months. The RN/DON will maintain the TB assessment in the infection control binder and esnure it is updated annually. Compliance will be reviewed during the monthly Quality Assurance Committee meeting for six months and annually thereafter. Any missed or incomplete assessments will result in immediate corrective action and retraining. Anticipated Date of Correction: May 15, 2026	5/15/26
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be	S 506	Plan of Correction - 44:70:06:17 Required Dietary In-service Training The facility submits the following Plan of Correction in response to the citation regarding failure to ensure required initial and annual dietary in-service training for five employees.	

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S 506	Continued From page 9 completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure five of five sampled employees (F, G, H, I, and J) had received initial or ongoing dietary in-service training on the required topics of food safety, handwashing, food handling/preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. Findings include: 1. Review of the personnel file for activities director F revealed she was hired on 9/20/24. There was no documentation to support that she had completed the dietary in-service training within 30 days of her hire date or annually.	S 506	Corrective Action Taken: All five identified employees (F, G, H, I, and J) immediately completed the required dietary in-service training covering all nine mandated topics. Documentation of completion was receieved for all active staff. A full audit of all employee files was conducted to identify any additional staff missing dietary training: no further deficiencies were found. The Administrator consulted with the Registered Dietitian to obtain approved training materials and confirm required content. This content was also approved by state representaitves present at the survey. Systemic Changes Implemented: The facility received a written Dietary In-Service Training Policy outlining required topics, timelines, and documentation standards from our registered dietitian. A standardized Dietary Training Checklist was added to each personnel file. The onboarding proces was revised to ensure all new employees receive the required dietary training prior to hire, and annual training is now scheduled and tracked through a centralized training calendar. Monitoring to Ensure Ongoing Compliance: The Administrator will review personnel files of current staff to verify completion and documentation of required dietary trainingand for all new hires and annual renewals. Monitoring results will be reviewed during the monthly Quality Assurance Committee meeting, with immediate corrective action take if any gaps are identified. Anticipated Date of Correction: May 18, 2026	5/18/26

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(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) COMPLETE DATE
S 506	Continued From page 10 2. Review of the personnel file for caregiver G revealed he was hired on 11/4/24. There was no documentation to support that he had completed the dietary in-service training within 30 days of his hire date or annually. 3. Review of the personnel file for registered medication aide (RMA) H revealed she was hired on 2/16/25. There was no documentation to support that she had completed the dietary in-service training within 30 days of her hire date or annually. 4. Review of the personnel file for cook I revealed she was hired on 1/22/26. There was no documentation to support that she had completed the dietary in-service training within 30 days of her hire date. 5. Review of the personnel file for RMA J revealed she was hired on 9/20/24. There was no documentation to support that she had completed the dietary in-service training within 30 days of her hire date or annually. 6. Interview on 5/5/26 at 4:30 p.m. with administrator A revealed he expected all employees to complete the required dietary training within 30 days of their hire date and annually. He was not aware of the dietary in-service requirements and would consult with registered dietitian K for guidance and training materials. 7. A policy regarding dietary in-service training was requested from administrator A on 5/5/26 at 4:30 p.m., but it was not provided by the end of the survey.	S 506		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41884	A. BUILDING: _____ B. WING _____	C 05/05/2026

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S 506	Continued From page 11	S 506		
S 775	44:70:09:02 Facility To Inform Resident Of Rights Prior to or at the time of admission, a facility shall inform the resident, both orally and in writing, of the resident's rights and of the rules governing the resident's conduct and responsibilities while living in the facility. The resident shall acknowledge in writing that the resident received the information. During the resident's stay the facility shall notify the resident, both orally and in writing, of any changes to the original information. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure an acknowledgement of having received a copy of the resident rights information was signed and dated by four of five sampled residents (1, 2, 4, and 5) or their representatives. Findings include: 1. Review of the care record for resident 1 revealed that she was admitted to the facility on 10/13/25. There was no documentation to support that the resident or her representative had acknowledged receipt of a copy of the residents' rights. 2. Review of the care record for resident 2 revealed that she was admitted to the facility on 3/17/26. There was no documentation to support that the resident or her representative had acknowledged receipt of a copy of the residents' rights.	S 775	Plan of Correction - 44:70:09:02 Facility to Inform Resident of Rights The facility submits the following Plan of Correction in response to the citation regarding failure to obtain written acknowledgment of receipt of resident rights information for four residents. Corrective Action Taken: Residents 1, 2, and 4 - and the representaitve for Resident 5 - were immediately provided a copy of the Resident Rights document. Written acknowledgments were obtained and placed in each resident's record. All current resident files were reviewed to ensure acknowledgements were present. The Administrator and RN/DON received immediate retraining on the requirement to obtain written acknowledgment at admission. Systemic Changes Implemented: The facility revised its admission process to include a mandatory Resident Rights Acknowledgement Form that must be signed and dated by the resident or representative before admission is finalized. The Residents' Rights policy was updated to clearly outline the requirement for written acknowledgment and the process for documenting receipt. The admission packed was reorganized to ensure the Resident Rights form is prominently included and cannot be bypassed. Monitoring to Ensure Ongoing Compliance: The Administrator will review all new admission files within 72 hours of admission for three months to verify that the Resident Rights Acknowledgment Form is completed and filed. After the initial three-month period, quarterly audits will be conducted for the remainder of the year. The RN/DON will maintain an admission checklist that included confirmation of the signed acknowledgment. Monitoring results will be reviewed during the monthly Quality Assurance Committe meeting, with immediate corrective action taken if an deficiencies are identified. Anticipated Date of Correction: May 15, 2026	5/15/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 775	Continued From page 12 3. Review of the care record for resident 4 revealed that he was admitted to the facility on 10/16/25. There was no documentation to support that the resident or his representative had acknowledged receipt of a copy of the residents' rights. 4. Review of the closed care record for resident 5 revealed that he was admitted to the facility on 10/9/25 and discharged on 2/12/26. There was no documentation to support that the resident or his representative had acknowledged receipt of a copy of the residents' rights. 5. Interview on 5/5/26 at 11:13 a.m. with administrator A and registered nurse/director of nursing (RN/DON) B revealed that they review the residents' rights with the resident, or their representative, at the time of admission, but they do not have them sign an acknowledgement that the information was received or understood. 6. Review of the provider's undated Residents' Rights in the Facility policy revealed, "The resident shall acknowledge in writing that [the] resident received the information."	S 775		~~6/3/26~~