

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CIRCLE OF CARE-ACKERMAN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7385 ACKERMAN AVE, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: THOMAS BADDELEY Title: Q/C manger
REPRESENTATIVE'S SIGNATURE

Date: 08/22/2026

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey completed at your facility on 07/30/2026. This facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was six. Six resident files and seven employee files were reviewed. The facility received a grade of B.			
Y 0074 SS= E	1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the	Y 0074	Plan of Correction #1 TagY 0074 Absolute Circle of Care Insp #80475 1. Corrective Action for Affected Individuals Employee #3: Last day worked was 7/8/2026. Employee #3 was removed from the active shift schedule. #3 was notified on 7/31/26 of the need to complete elder abuse training. repeated attempts to contact #3 have been unanswered as of 8/21/26. #3 will have to provide valid proof of compliance prior to resuming shifts, however, we believe she has quit.	08/04/2026

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	license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and		• Employee #2 and #5: Immediately upon discovery of the deficiency on 7/31/2026, Administrator/Designee required these staff members to complete the training before their next scheduled shift. • Both E2 & E5 successfully completed the annual Elder Abuse training on 7/31/26 and 8/4/26 respectively. Certificates of completion have been printed and filed in their respective personnel records. 2. Identification and Systemic Correction for Other Residents/Staff • Audit: The Administrator/Designee conducted an audit of all current employee personnel files on 7/31/26 to review annual training compliance, specifically verifying that all mandatory elder abuse training is up to date. • Policy Review & System Update: The Administrator implemented a Master Employee Training Tracking Log (electronic/spreadsheet) that flags required annual training renewals 30 days prior to their expiration date. 3. Systemic Changes & Preventive Measures	

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	(2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on interview and document review, the facility failed to ensure 3 of 7 employees had completed		- All current and future staff will be notified that mandatory annual training modules must be completed at least 15 days prior to the annual due date. - Mandatory training compliance/completion will be verified monthly by administrator/designee. Staff who are non-compliant by their annual renewal date will be removed from the active shift schedule until training is completed and verified. 4. Quality Assurance & Monitoring Plan - The Administrator or Quality Assurance Designee will conduct a monthly audit of the Master Employee Training Tracking Log and personnel files for the next 6 months to ensure full compliance. - Audit findings will be documented and reviewed during quarterly Quality Assurance (QA) meetings. If compliance is maintained after 6 months, monitoring will transition to routine quarterly audits. Completion Date: 8/30/26 Title of Responsible Person: Facility Administrator/designee	

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	annual elder abuse training (Employee #2, #3, and #5). Findings include: Employee #2 (E2) E2 was hired on 04/22/2026 as a Caregiver. E2's file documented a completed Elder Abuse training dated 06/12/2025. E2's file lacked documented evidence of Elder Abuse training for 2026. Employee #3 (E3) E3 was hired on 03/09/2026 as a Caregiver. E3's file documented a completed Elder Abuse training dated 05/28/2025. E3's file lacked documented evidence of Elder Abuse training for 2026. Employee #5 (E5) E5 was hired on 05/10/2026 as a Caregiver. E5's file documented a completed Elder Abuse training dated 06/26/2025. E5's file lacked documented evidence of Elder Abuse training for 2026. On 07/30/2026 in the afternoon, the Administrator acknowledged the lack of documented evidence of an annual Elder Abuse training for E2, E3, and E7. Severity: 2 Scope: 2			
Y 0102 SS= F	NAC 449.200 and R043-22 (d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on document review and interview, the facility failed to ensure 1 of 7 (Employee #5) had completed	Y 0102	Plan of Correction #2 TagY 0102 Absolute Circle of Care Insp #80475 1. Corrective Action for Affected Individuals	08/12/2026

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	a pre-employment physical examination, failed to ensure 4 of 7 employees (Employee #2, #4, and #7) had completed a pre-employment two-step tuberculosis (TB) test, and failed to ensure 1 of 7 employees (Employee #1) completed an annual TB test. Findings include: Employee #1 (E1) E1 was hired on 10/15/2025 as the Administrator. E1's file documented a two-step TB dated 07/14/2025 and 07/21/2025 with a negative result. E1's file lacked documentation of a completed annual TB test for 2026. Employee #2 (E2) E2 was hired on 04/22/2026 as a Caregiver. E2's file lacked documented evidence of an initial two-step TB test. Employee #4 (E4) E4 was hired on 03/19/2026 as a Caregiver. E4's file documented an initial one-step TB test dated 03/04/2026 with a negative result. E4's file lacked documented evidence of a second step TB test. Employee #5 (E5) E5 was hired on 05/10/2026 as a Caregiver. E5's file lacked documented evidence of a pre-employment physical examination. Employee #7 (E7) E7 was hired on 06/07/2026 as a Caregiver. E7's file lacked documented evidence of an initial two-step TB test. On 07/30/2026 in the afternoon, E1 acknowledged the lack of documented evidence of a pre-employment physical		0 Employee #1 (Administrator): On 8-3-26 E1 Completed an annual TB screening/test;negative results have been filed in E1's personnel record. 0 Employee #2 (Caregiver): On 8-5-26 E2 Completed an annual TB screening/test;negative results have been filed in E2's personnel record. 0 Employee #4 (Caregiver): On 8-3-26 E4 Completed an annual TB screening/test;negative results have been filed in E4's personnel record. 0 Employee #5 (Caregiver): 8-04-26 E5 Completed a pre-employment physical examination; official clearance documentation from a healthcare provider has been placed in E5's personnel file. • Employee #7 (Caregiver): On 8-12-26 E7 Completed an annual TB screening/test; negative results have been filed in E7's personnel record. 2. Identification and Systemic Correction for all Residents and Staff • Audit: The Administrator/Designee conducted an audit of all current employee personnel files on 7/31/26 to review annual training compliance, specifically verifying that all TB tests are compliant.	

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	examination for E5, the lack of documented evidence of a pre-employment two-step TB test for E2, E4, and E7, and the lack of documented evidence of an annual TB test for E1. Severity: 2 Scope: 3		Policy Review & System Update: The Administrator implemented a Master Employee Training Tracking Log (electronic/spreadsheet) that flags required annual training renewals 30 days prior to their expiration date. 3. Systemic Changes &Preventive Measures - All current and future staff will be notified that mandatory annual training must be completed at least 15 days prior to the annual due date. - Mandatory training compliance/completion will be verified monthly by administrator/designee. Staff who are non-compliant by their annual renewal date will be removed from the shift schedule until training is completed and verified. 4. Quality Assurance &Monitoring Plan - The Administrator or Quality Assurance Designee will conduct a monthly audit of the Master Employee Training Tracking Log and personnel files for the next 6 months to ensure full compliance.	

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			Audit findings will be documented and reviewed during quarterly Quality Assurance (QA) meetings. If compliance is maintained after 6 months, monitoring will transition to routine quarterly audits. Completion Date: 8/12/26 Title of Responsible Person: Facility Administrator/designee	
Y 0450 SS= D	NAC 449.231 First aid and cardiopulmonary resuscitation. 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be certified in first aid and cardiopulmonary resuscitation in accordance with the requirements of section 2 of R089-24. Reference - R089-24 Sec. 2. 1. A person who is required by this chapter to be certified in first aid, cardiopulmonary resuscitation or first aid and cardiopulmonary resuscitation may complete any training, course or program to become certified or to renew certification, as applicable, through: (a) In-person instruction only; (b) A combination of in-person instruction and virtual or electronic instruction, if interactive, hands-on skills training or skills verification is provided in person; or (c) Virtual or electronic instruction only, if	Y 0450	Plan of Correction (POC)#3 Y-450 Absolute Circle of Care Insp #80475 1. Immediate Corrective Action for the Specific Individual Employee #3: Last day worked was 7/8/2026. E3 was removed from the active shift schedule. E3 was notified on 7/31/26 of the need to complete elder abuse training. repeated attempts to contact E3 have been unanswered as of 8/21/26. E3 will have to provide valid proof of compliance prior to resuming shifts, however, we believe she has quit.	08/01/2026

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	interactive, hands-on skills training or skills verification is not prerecorded. 2. If a certificate is earned in accordance with the requirements of subsection 1, the Division shall accept a certificate issued by the American Red Cross, the American Heart Association, the Health and Safety Institute or another similar nationally recognized organization as proof of certification or renewal of certification. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 7 employees completed cardiopulmonary resuscitation (CPR) and first-aid training biennially (Employee #3). Employee #3 (E3) E3 was hired on 03/04/2026 as a Caregiver. E3's file documented a completed CPR and first-aid training on 05/30/2024. E3's file lacked documented evidence of a biennially completed CPR and first-aid training for 2026. On 07/30/2026 in the afternoon, the Administrator could not provide documentation E3 completed CPR and first-aid training biennially. Severity: 2 Scope: 1		2. Identification and Systemic Correction for all Residents and Staff Audit: The Administrator/Designee conducted an audit of all current employee personnel files on 7/31/26 to review annual training compliance, specifically verifying that all CPR Certs are current. Policy Review & System Update: The Administrator implemented a Master Employee Training Tracking Log (electronic/spreadsheet) that flags required annual training renewals 30 days prior to their expiration date. 3. Systemic Changes & Preventive Measures - All current and future staff will be notified that mandatory annual training must be completed at least 15 days prior to the annual due date. - Mandatory training compliance/completion will be verified monthly by administrator/designee. Staff who are non-compliant by their annual renewal date will be removed from the shift schedule until training is completed and verified.	

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			4. Quality Assurance &Monitoring Plan - The Administrator or Designee will conduct a monthly audit of the Master Employee Training Tracking Log and personnel files for the next 6 months to ensure full compliance. - Audit findings will be documented and reviewed during quarterly Quality Assurance (QA) meetings. If compliance is maintained after 6 months, monitoring will transition to routine quarterly audits. Completion Date: 8/30/26 Title of ResponsiblePerson:Facility Administrator/designee	
Y 0930 SS= D	NAC 449.2749 Maintenance and contents of separate file of information concerning each resident; contents; confidentiality of information. 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a	Y 0930	Plan of Correction #4 TagY 0950 Absolute Circle of Care Insp #80475 1. Corrective Action forAffected Individuals Resident #6 (R6) was immediately evaluated for signs and symptoms of active tuberculosis (TB), with no clinical symptoms noted.	08/04/2026

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	place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services.		Resident #6: On 8-3-26 R6 Completed an annual TB screening/test; negative results have been filed in R6's personnel record. - Official documentation confirming a negative result was placed in R6's medical record on or before 8-4-26. 2. Systemic Changes & Identification of Other Potentially Affected Residents - The Administrator conducted an audit of all current resident medical records to ensure every resident has documented, up-to-date annual TB screening. - A Resident Health Screening Master Log (physical and electronic) is being created to centralize and track annual TB testing dates alongside resident admission dates. 3. Preventive Measures & Monitoring Plan - The Administrator or designated facility staff will conduct a monthly audit of the Resident Health Screening Master Log to identify upcoming annual TB tests due within 30 days.	

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	(e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i) The name and telephone number of the vendors and medical professionals that		- Calendar alerts and physician order prompts will be instituted 30 days prior to the due date to ensure health screenings are administered and documented on time. - The Administrator will review medical chart compliance quarterly during Quality Assurance reviews to ensure continuous oversight. 4. Title of Person Responsible & Completion Date Responsible Party: Facility Administrator Completion Date: August 30, 2026	

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	provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the bureau who is acting in his capacity as an employee of the bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure an annual tuberculosis (TB) test was completed for 1 of 6 residents (Resident #6). Findings include:			

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	Resident #6 (R6) R6 was admitted on 04/16/2026 with diagnoses including dementia, hyperlipidemia, hypertensive heart failure, and paroxysmal atrial fibrillation. R6's file revealed R6 completed a two-step TB test dated 06/25/2025 and 07/04/2025 with a negative result. R6's file lacked documentation for an annual TB test. On 07/30/2026 in the morning, the Administrator acknowledged R6's file lacked documented evidence of annual TB test for 2026. Severity: 2 Scope: 1			
Y 1035 SS= E	NAC 449.2768 Residential facility which provides care to persons with Alzheimer's disease: Alzheimer's/dementia Training: 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which holds an endorsement as a residential facility which provides care to persons with Alzheimer's disease or other forms of dementia pursuant to NAC 449.2754 shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes, in addition to the training required by NAC 449.196: (1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of tier 2 training. (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. (3) If such an employee is licensed or certified by an occupational licensing board,	Y 1035	#5 Y-1035 Alzheimer's Absolute Circle of Care Insp #80475 1. Immediate Corrective Action for Specific Individuals Employee #3: Last day worked was 7/8/2026. E3 was removed from the active shift schedule. E3 was notified on 7/31/26 of the need to complete elder abuse training. repeated attempts to contact E3 have been unanswered as of 8/21/26. #3 will have to provide valid proof of compliance prior to resuming shifts, however, we believe she has quit. Employee #6 (E6) completed the required #3 hour training course on 08-06-26 2. Identification and Systemic Correction for Other Residents/Staff Audit: The Administrator/Designee	08/06/2026

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	at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). (b) The facility maintains proof of completion of the hours of training and continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete the training or continuing education. 2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he has completed that training within the previous 12 months. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 7 employees obtained 1) two hours of Alzheimer's training within the first 40 hours of employment, 2) eight hours of Alzheimer's training within the first 90 days of employment, or 3) three hours of Alzheimer's training annually (Employees #3 and #6). Findings include:		conducted an audit of all current employee personnel files on 7/31/26 to review annual training compliance, specifically verifying that all mandatory Alzheimer's training is up to date. Policy Review & System Update: The Administrator implemented a Master Employee Training Tracking Log (electronic/spreadsheet) that flags required annual training renewals 30 days prior to their expiration date. 3. Systemic Changes & Preventive Measures - All current and future staff will be notified that mandatory annual training must be completed at least 15 days prior to the annual due date. - Mandatory training compliance/completion will be verified monthly by administrator/designee. Staff who are non-compliant by their annual renewal date will be removed from the active shift schedule until training is completed and verified. 4. Quality Assurance & Monitoring Plan	

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	Employee #3 (E3) E3 was hired on 03/09/2026 as a Caregiver. E3's file lacked documented evidence of two hours of Alzheimer's training within the first 40 hours of employment and eight hours of Alzheimer's training within the first 90 days of employment. Employee #6 (E6) E6 was hired on 05/01/2026 as a Caregiver. E6's file documented Alzheimer's training on 06/09/2025. E6's file lacked documented evidence of three hours of annual Alzheimer's training. On 07/30/26 in the afternoon, the Administrator acknowledged the facility lacked documented evidence E3 and E6 had completed the required initial and/or annual Alzheimer's training. Severity: 2 Scope: 2		- The Administrator or Quality Assurance Designee will conduct a monthly audit of the Master Employee Training Tracking Log and personnel files for the next 6 months to ensure full compliance. - Audit findings will be documented and reviewed during quarterly Quality Assurance (QA) meetings. If compliance is maintained after 6 months, monitoring will transition to routine quarterly audits. Completion Date: 8/30/26 Title of Responsible Person: Facility Administrator/designee	
Y 1825 SS= D	NAC 449.0109 Designation and training of person responsible for infection control. 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less	Y 1825	#6 Y-1825 Infectioncontrol Absolute Circle of Care Insp #80475 1. Immediate CorrectiveActions Taken for Affected Individuals Action Taken: Employee #7 (E7) was enrolled in an approved, nationally recognized 15-hour infection control training program concerning the control of infectious diseases (CDC). Certificate of completion was obtained on 806/26	08/06/2026

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	than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the secondary designee responsible for infection control obtained the required initial 15 hours of training by a nationally recognized organization concerning the control of infectious disease for 1 of 7 employees (Employee #7). Findings include: Employee #7 (E7) E7 was hired on 06/07/2026 as a Caregiver. E7's file lacked documented evidence of an initial 15-hour infection control training by a nationally recognized organization concerning the control of infectious disease. On 07/30/2026 in the afternoon, the Administrator acknowledged E7 had not		2. Identification and Systemic Correction for Other Residents/Staff Audit: The Administrator/Designee conducted an audit of all current employee personnel files on 7/31/26 to review annual training compliance, specifically verifying that all infection control training is up to date. Policy Review & System Update: The Administrator implemented a Master Employee Training Tracking Log (electronic/spreadsheet) that flags required annual training renewals 30 days prior to their expiration date. 3. Systemic Changes & Preventive Measures - All current and future staff will be notified that mandatory annual training must be completed at least 15 days prior to the annual due date. - Mandatory training compliance/completion will be verified monthly by administrator/designee. Staff who are non-compliant by their annual renewal date will be removed from the active shift schedule until training is completed and verified.	

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	completed the initial 15 hours of infection control training by a nationally recognized organization concerning the control of infectious disease. Severity: 2 Scope: 1		4. Quality Assurance &Monitoring Plan - The Administrator or Quality Assurance Designee will conduct a monthly audit of the Master Employee Training Tracking Log and personnel files for the next 6 months to ensure full compliance. - Audit findings will be documented and reviewed during quarterly Quality Assurance (QA) meetings. If compliance is maintained after 6 months, monitoring will transition to routine quarterly audits. Completion Date: 8/30/26 Title of Responsible Person: Facility Administrator/designee	