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	10911	A. BUILDING _____ B. WING _____	07/15/2026

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ALTA CARE HOME, INC.	2007 ALTA DRIVE, LAS VEGAS, NEVADA ,89106

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RFG 0001-Deficiencies	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	RFG 0001-Deficiencies		

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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 State Licensure survey at your facility on 07/15/26. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of the survey was eight. Eight resident files and four employee files were reviewed. The facility received a grade of B.			
Y 0250 SS= F	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged.	Y 0250	1. Corrective Action Taken Immediately upon notification of the deficiency on 07/15/2026, all expired food items identified by the surveyor, including the hot dog buns, nutritional yeast flakes, garlic salt, basil leaves, and shredded carrots, were removed from the kitchen and pantry and discarded. The kitchen pantry, refrigerator, and food storage areas were inspected to verify that no additional expired	07/15/2026

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	4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored. Inspector Comments: Based on observation and interview, the facility failed to ensure expired foods were discarded. Findings include: On 07/15/26 in the morning, the following food items were in the kitchen and storage area and were expired. In the main kitchen pantry located in the kitchen, the following were found: Hot dog buns had an expiration date of 07/01/26 and 07/12/26. An open container of nutritional yeast flakes had an expiration date of 04/14/24. An open container of garlic salt had an expiration date of 01/16/22. An open container of basil leaves had an expiration date of 09/29/23. On 07/15/26 in the morning, the following food item was on the kitchen counter and was expired.		food items remained. **2. Measures to Prevent Recurrence** The facility has implemented a food inventory and expiration date monitoring system. All caregivers have been re-educated on proper food storage requirements under NAC 449.217, including the requirement to routinely inspect all food items, immediately discard expired products, rotate stock using the First-In, First-Out (FIFO) method, and inspect expiration dates before food preparation and service. **3. Monitoring System** The Administrator or designee will conduct and document weekly inspections of all food storage areas, including the pantry, refrigerator, and freezer, to verify that no expired food items are present. Any expired items identified during these inspections will be discarded immediately. **4. Person Responsible :**	

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	An open package of shredded carrots had an expiration date of 06/12/26. On 07/15/26 in the morning, a Caregiver was not aware the food was expired and acknowledged the expired items should have been discarded. Severity: 2 Scope: 3		Administrator 5. Completion Date Completed: July 15, 2026	
Y 0515 SS= E	NAC 449.259 **Supervision of residents.** 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of	Y 0515	1. Corrective Action for the Deficient Practice Resident #1 and Resident #2 received comprehensive annual Person-Centered Service Plan (PCP) reviews. The plans were reviewed with each resident and/or the resident's representative, updated to reflect the residents' current needs, signed by all required parties, and placed in the residents' medical records. The deficiency was corrected immediately upon identification. 2. How Other Residents Will Be Protected A 100% audit of all current resident records was conducted to verify that each resident has a current annual Person-Centered Service Plan completed within the required	07/16/2026

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	leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 8 residents had a person-centered care plan (PCP) completed annually. (Resident #1 and Resident #2) Findings include: Resident #1 (R1) R1 was admitted on 06/12/25 with diagnoses including Type 2 diabetes mellitus and hyperlipidemia. R1's file revealed an initial PCP completed on 06/12/25. R1's file lacked documented evidence of an annual PCP completed in 2026. Resident #2 (R2) R2 was admitted on 03/30/24 with diagnoses including chronic obstructive		annual timeframe. Any missing or overdue PCPs identified during the audit were completed immediately to ensure compliance. 3. Systemic Changes to Prevent Recurrence The facility has implemented the following corrective measures: * A Person-Centered Service Plan tracking log has been established to monitor annual due dates for every resident. * The Administrator and/or designee will review the tracking log monthly to identify PCPs approaching their annual review date. * Calendar reminders have been implemented at least 30 days before each annual PCP is due. * Staff responsible for resident records received re-education regarding the requirements of NAC 449.259, emphasizing that each resident's Person-Centered Service Plan must be reviewed and updated at least annually and documented in the resident's record. * PCP completion will be added to the facility's admission and annual	

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	pulmonary disease and acquired absence of the left toe. R2's file revealed an initial PCP completed on 03/30/24 and an annual PCP completed on 03/30/25. R2's file lacked documented evidence of an annual PCP completed in 2026. On 07/15/26 in the morning, E2 confirmed R1 and R2 did not have an annual PCP completed in 2026. Severity: 2 Scope:2		record review checklist. 4. Monitoring The Administrator or designee will audit 100% of resident Person-Centered Service Plans monthly for three (3) consecutive months to verify timely annual completion and documentation. Audit findings will be documented, and any deficiencies identified will be corrected immediately. Results will be reviewed during the facility's meeting to ensure continued compliance. 5. Completion Date All corrective actions were completed by July 16, 2026 Responsible Person: Administrator/Licensee Copies of Residents' 1 and 2 Person Center Service Plans are herein attached as Tags Y-0515	

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Y 0620 SS= D	**NAC 449.2702 and R089-24** 4. Except as otherwise provided in this section and NAC 449.2736 and 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; (d) Requires skilled nursing or other medical supervision on a 24-hour basis; (e) Requires gastrostomy care; (f) Requires vacuum-assisted wound closure therapy; (g) Requires dialysis, if the person is unable to leave the facility to obtain dialysis services; (h) Suffers from a serious staphylococcus infection or other serious infection; or (i) Suffers from any other serious medical condition or requires care not described in NAC 449.2712 to 449.2734, inclusive. 5. A residential facility that provides care to persons with Alzheimer's disease or other severe dementia, as described in paragraph (a) of subsection 2 of NRS 449.1845, may admit or retain a resident who requires confinement in locked quarters.	Y 0620	**1. Corrective Action taken:** The Administrator reviewed Resident #1's medical exemption status. The facility promptly gathered the required supporting documentation and submitted the missing information requested by the Bureau to complete the medical exemption application. The facility will ensure Resident #1 remains under appropriate physician and hospice services while awaiting the Bureau's determination. If the exemption is denied, the facility will coordinate an appropriate discharge/transfer in accordance with state regulations and physician recommendations. **2. Identification of Other Residents** The Administrator conducted a comprehensive audit of all current residents to determine whether any other resident met the definition of bedfast or otherwise required a Bureau-approved medical exemption. Any resident identified as requiring an exemption will have the appropriate application completed and submitted immediately. **3. Systemic Changes**	07/22/2026

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	6. If a governmental entity with jurisdiction, including, without limitation, a local board of health, a local health officer, the Division, the Chief Medical Officer or the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, declares the existence of an epidemic or pandemic, a residential facility located in the area in which the epidemic or pandemic is occurring may permit a resident suffering from a serious infection to remain a resident if the resident does not have symptoms that require a higher level of care than the residential facility is capable of providing. 7. A person may not reside in a residential facility if the person's physician or the Bureau determines that the person does not comply with the requirements for eligibility. 8. As used in this section, "restraint" means: (a) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms; (b) A manual method for restricting a resident's freedom of movement or the resident's normal access to his or her body; or (c) A device or material or equipment which is attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or the resident's normal access to his or her body. **Reference - R089-24 Sec. 9.**		The facility has revised its admission and ongoing resident assessment procedures to require verification that any resident who becomes bedfast has an approved Bureau medical exemption before continued retention, unless otherwise authorized by the Bureau. An exemption tracking log has been implemented to monitor submission dates, Bureau correspondence, missing documentation requests, approval status, and renewal dates. The Administrator and nursing staff have been re-educated regarding Nevada requirements for medical exemption requests and the prohibition against retaining a bedfast resident without Bureau approval. **4. Monitoring** The Administrator or designee will review all residents requiring medical exemptions weekly for the first 30 days, then monthly for the next three months, to verify that all required applications are complete, submitted timely, and approved prior to resident retention. Findings will be documented, and any deficiencies identified will be corrected immediately. **5. Completion Date:** 07/22/2026	

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	"Bedfast" means: 1. Incapable of changing his or her position in bed without the assistance of another person; or 2. Immobile. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure a medical exemption request was approved by the Bureau to retain 1 of 8 residents who were bedfast (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 06/12/25 with diagnoses including Type 2 diabetes mellitus and hyperlipidemia. On 07/02/25 in the morning, R1 was observed lying in bed and was able to answer questions regarding condition. R1 verbalized not being able to move at all in bed without assistance from staff. R1's file revealed an undated email from the Bureau giving the facility a provisional exemption and the application was not approved due to missing information from the facility. R1's file lacked documented evidence of an approved medical exemption for R1. Review of the Bureau's medical exemptions applications database revealed the facility submitted an application on 08/21/25 but had not received approval to retain R1.		Copy of Bedfast Application is herein attached as Tag 620) 07/22/2026	

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	On 07/15/26 in the morning, a hospice Nurse verbalized R1 was bedfast and was not able to position themself independently. On 07/15/26 in the morning, E2 acknowledged the facility did not have an approved medical exemption request to retain R1. Severity: 2 Scope: 1			
Y 0850 SS= E	NAC 449.274 and R043-22 **Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records.** 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or	Y 0850	1. Corrective Action for the Residents After survey, Administrator reviewed the records of Resident #1 and Resident #2. The Administrator scheduled annual physical examination appointments with each resident's attending physician. The Administrator or designee will obtain the completed examination documentation and file it in each resident's medical record upon receipt . 2. Identification of Other Residents The Administrator or designee completed an audit of all current resident records to verify that annual physical examinations were current and properly documented as required by Nevada regulations	07/16/2026

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	injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1		governing resident care and medical record documentation. For any resident found to be overdue, the Administrator or designee will schedule an appointment immediately and the completed documentation will be obtained by the Administrator or designee and placed in the resident's record to bring the facility into compliance with applicable regulatory obligations. 3. Systemic Changes The facility has implemented a tracking system for annual physical examinations and other required physician assessments to ensure compliance with Nevada regulatory requirements. The Administrator is responsible for overseeing the tracking system, and designated staff are responsible for maintaining the schedule and monitoring due dates. The Administrator has reeducated applicable staff on the Nevada requirements for annual physical examinations, the obligation to maintain current documentation in each resident's medical record, and the facility's responsibility to ensure timely completion of required assessments. Designated staff will use calendar reminders to notify the	

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	resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on interview and record review, the facility failed to ensure 2 of 8 residents received an annual physical examination. (Resident #1 and Resident #2) Findings include: Resident #1 (R1) R1 was admitted on 06/12/25 with diagnoses including Type 2 diabetes mellitus and hyperlipidemia. R1's medical record revealed a History and Physical dated 05/21/25. R1's medical record lacked documented evidence an annual physical examination was completed in 2026. Resident #2 (R2) R2 was admitted on 03/30/24 with diagnoses including chronic obstructive pulmonary disease and acquired absence of the left toe. R2's medical record revealed a History and Physical dated 03/26/25. R2's medical record lacked documented evidence an annual physical examination was completed in 2026. On 07/15/26 in the morning, E2 acknowledged an annual physical examination was not completed and on file for R1 and R2.		Administrator and responsible staff at least 30 days before each annual examination is due so that compliance deadlines are met. 4. Monitoring The Administrator or designee will conduct monthly audits of resident medical records for three 3 months to ensure annual physical examinations are completed on time and documented appropriately in accordance with Nevada regulatory requirements. The Administrator will review the audit results, and any deficiencies identified will be corrected immediately by the Administrator or designee to maintain compliance. Additional staff education will be provided by the Administrator as needed to reinforce regulatory expectations and facility compliance obligations. 5. Completion: 07/16/2026 Corrected on: 07/16/2026	

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	Severity: 2 Scope: 2			
Y 0870 SS= F	NAC 449.2742 **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC	Y 0870	Facility immediately initiated a corrective action to ensure that a current medication regimen review is completed for each affected resident by the appropriate qualified healthcare professional. The facility will obtain and maintain documentation of each completed medication regimen review in the resident's clinical record. The facility will also ensure that any recommendations or changes resulting from the medication regimen review are communicated to the resident's attending physician, responsible party, pharmacy, and appropriate facility staff, as applicable, and that any required follow-up is completed and documented. 2. Identification of Other Residents Who May Be Affected The facility conducted, and/or will conduct, a comprehensive review of the clinical records of all current residents to determine whether each resident has a documented medication regimen review	06/10/2026

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	449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure a medication regimen review was completed every six months for 6 of 8 residents. (Resident #1, #2, #3, #4, #5, and #6) Findings include: Resident #1 (R1) R1 was admitted on 06/12/25 with diagnoses including Type 2 diabetes mellitus and hyperlipidemia. R1's file revealed a medication regimen review dated 12/15/25 and lacked documented evidence of a medication review within the last six months. Resident #2 (R2) R2 was admitted on 03/30/24 with diagnoses including chronic obstructive pulmonary disease and acquired absence of the left toe. R2's file revealed a medication regimen review dated 07/15/25 and lacked documented evidence of a medication review within the last six months. Resident #3 (R3)		completed within the required six-month timeframe. Any resident identified as lacking a current medication regimen review will have the review scheduled and completed as soon as possible by the appropriate qualified healthcare professional. Documentation of the review and any resulting recommendations or interventions will be maintained in the resident's record. The facility will also review the medication regimen review dates for newly admitted residents to ensure that the required six-month review cycle is established and maintained. 3. Systemic Changes to Prevent Recurrence The facility has reviewed its medication management procedures and implemented a system to ensure that medication regimen reviews are tracked and completed at least every six months, as required.	

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	R3 was admitted on 11/17/25 with diagnoses including bilateral primary osteoarthritis of the knee and emphysema. R3's file revealed a medication regimen review dated 11/17/25 and lacked documented evidence of a medication review within the last six months. Resident #4 (R4) R4 was admitted on 12/15/25 with diagnoses including encounter for orthopedic aftercare following surgical amputation and chronic obstructive pulmonary disease. R4's file revealed a medication regimen review dated 12/16/25 and lacked documented evidence of a medication review within the last six months. Resident #5 (R5) R5 was admitted on 10/25/25 with diagnoses including displaced fracture of base of neck and peripheral vascular disease R5's file revealed a medication regimen review dated 10/26/25 and lacked documented evidence of a medication review within the last six months. Resident #6 (R6) R6 was admitted on 08/22/24, with diagnoses including gait abnormality and chronic atrial fibrillation. R6's file revealed a medication regimen review dated 08/22/25 and lacked documented evidence of a medication review within the last six months. On 07/15/26 in the morning, E2 acknowledged the resident files for R1,		A centralized medication regimen review tracking log will be maintained and will include, at a minimum, the resident's name, date of the most recent medication regimen review, date the next review is due, and the date the review was completed. The Administrator or designee will review the tracking log monthly and will ensure that medication regimen reviews approaching their due date are scheduled in advance. The facility will establish a reminder process to prevent any medication regimen review from becoming overdue. All newly admitted residents will be added to the tracking system upon admission, and the facility will verify the date of the resident's most recent medication regimen review and establish the appropriate next review date. Staff responsible for maintaining resident clinical records and medication documentation will be educated regarding the requirement for medication regimen reviews and the facility's tracking and documentation procedures.	

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	R2, R3, R4, R5, and R6 lacked documented evidence of a current medication review. Severity: 2 Scope: 3		4. Monitoring and Quality Assurance The Administrator or designee will conduct a monthly audit of 100% of resident records for a period of three consecutive months to verify that medication regimen reviews are current, completed at least every six months, and properly documented. Following the initial three-month monitoring period, the facility will continue to review the medication regimen review tracking log monthly and conduct quarterly audits of resident records for a minimum of three additional months. If an audit identifies a missed, overdue, or inadequately documented medication regimen review, immediate corrective action will be taken. The Administrator or designee will determine the reason for the deficiency, ensure the required review is completed, and provide additional staff education or corrective action as necessary. The results of the audits will be documented and maintained by the	

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			facility. Any identified trends or recurring issues will be addressed through the facility's Quality Assurance/Performance Improvement process, as applicable 5. Person responsible: Administrator Completion Date: 06/10/2026 Corrected on: 06/10/2026	
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 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.	Y 0930	1. Corrective Action Taken for the Residents Identified in the Citation: The facility immediately reviewed the records of Resident #1 and Resident #2 and identified the missing documentation of the required annual TB screening. The facility initiated corrective action to ensure that the required annual TB screenings are completed and that the results are obtained and maintained in each resident's file. The resident records will be updated with the appropriate documentation upon completion/receipt of the required screening.	07/15/2026

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	(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. (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		2. Identification of Other Residents Who May Be Affected: The facility conducted, and will continue to conduct, a comprehensive review of the TB screening records for all current residents to ensure that each resident has documentation of the required initial and annual TB screening, as applicable. Any missing or outdated documentation identified during the review will be addressed immediately and documented in the resident's file. 3. Systemic Changes to Prevent Recurrence: The facility has implemented a tracking system for all required resident TB screenings. The Administrator/designee will maintain a TB screening tracking log that identifies each resident, the date of the most recent TB screening, and the due date for the next required screening. The Administrator/designee will review the tracking log monthly and ensure that screenings are scheduled and completed timely. Documentation of completed screenings and results will be placed in the appropriate resident file.	

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	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 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		In addition, TB screening due dates will be incorporated into the facility's compliance calendar to provide advance notice of upcoming requirements and prevent screenings from becoming overdue. 4. Staff Education: The Administrator/designee will provide education to all applicable staff responsible for resident records and health-related documentation regarding the facility's TB screening requirements, the importance of timely annual screening, and the requirement to maintain supporting documentation in each resident's file. Staff will also be instructed to immediately report any missing, incomplete, or overdue TB screening documentation to the Administrator/designee. 5. Monitoring and Quality Assurance: The Administrator/designee will audit 100% of resident files for TB screening compliance monthly for three consecutive months. Thereafter, TB screening compliance will be reviewed as part of the facility's ongoing quality assurance/compliance monitoring process. Any deficiency identified during an audit will be corrected immediately and the findings will be	

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	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 interview and record review, the facility failed to ensure a tuberculosis (TB) screening was completed annually for 2 of 8 residents. (Resident #1 and Resident #2) Resident #1 (R1) R1 was admitted on 06/12/25 with diagnoses including Type 2 diabetes mellitus and hyperlipidemia. R1 had an initial TB screening completed on 06/01/25. R1's file lacked documented evidence of an annual TB screening in 2026. Resident #2 (R2) R2 was admitted on 03/30/24 with		reviewed with responsible staff. The Administrator will maintain documentation of all audits, corrective actions, and staff education. Person responsible: Administrator Date completed: 07/15/2026 Copies of TB test results of Res 1 and 2 are herein attached . Corrected on: 07/15/2026	

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	diagnoses including chronic obstructive pulmonary disease and acquired absence of the left toe. R2 had an annual TB screening completed on 03/19/25. R2's file lacked documented evidence of an annual TB screening in 2026. On 07/15/26 in the morning, E2 acknowledged R1 and R2's files lacked evidence of an annual TB test and was unable to provide documentation of an annual TB screening for R1 and R2. Severity: 2 Scope:1			