STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	413	A. BUILDING _____ B. WING _____	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA SUMMIT RIDGE	4880 SUMMIT RIDGE DRIVE, RENO, NEVADA ,89523

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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 survey and change in category application review completed at your facility on 01/05/2026. The facility is licensed for 85 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, and assisted living services, 63-Category I residents, and 22-Category II residents. The census at the time of the survey was 71. Fifteen resident records and 15 employee records were reviewed. The facility received a grade of C.			
Y 0515 SS= F	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	Y 0515	●□□□□□□□□Person-centered services are incorporated intoeach resident's assessment, Plan of Care, and Physician's Report documentationto ensure that each resident's individual preferences, needs, goals, andsupport requirements are identified and addressed prior to admission. Laundryservices have also been added to each resident's Plan of Care to ensure thisservice is clearly identified and provided in accordance with the resident'sindividualized needs and preferences. Moving forward, the Resident Services Director and ExecutiveDirector will review all admission documentation prior to each resident'sphysical move-in to verify that the assessment, Plan of Care, and Physician'sReport have been completed and include all required person-centered serviceinformation, including laundry services. Any missing or incompletedocumentation will be corrected before the resident is admitted to ensureongoing compliance with applicable	01/07/2026

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	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 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, document review and interview, the facility failed to develop complete person-centered service plans for 15 of 15 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15). Findings include: On 01/05/2026, service plans for 15 of 15 sampled residents lacked the following: -provisions concerning activities of daily living, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services. -the way the facility will ensure the resident		regulations and to support the delivery of individualized,person-centered care. The plan of care has been updated to include the required information.	

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	was able attend the religious service of their choice and participate in personal and private pastoral counseling. -the type of protective supervision necessary for each resident. -the way caregivers would be informed of the type of protective supervision for each resident. -the permission to leave and enter the facility, and physical and mental capabilities for each resident to do so. -laundry services for the resident unless the resident elects in writing to make other arrangements and the manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable. -a written program of activities for the resident that includes scheduled and unscheduled activities suited to the resident's interests and capacities. -the steps to inform how each resident's valuables would be protected. On 01/05/2026 at 11:46 AM, the Resident Services Director confirmed the residents' service plans were not complete and lacked documentation of all the required information to be included in the service plans. Severity: 2 Scope: 3			
Y 0522 SS= D	NAC 449.259 (k) If the resident has Alzheimer's disease or another form of dementia, measures to address that dementia and ensure the safety of the resident in the facility, including, without limitation: (1) Any measures taken pursuant to NAC 449.2754 or 449.2756; and (2) Provisions for the transfer of the resident pursuant to NAC 449.2706 if: (I) It is determined through an assessment conducted pursuant to paragraph (c) of subsection 1 of NRS 449.1845 that the resident meets the criteria prescribed in paragraph (a) of subsection 2 of that section; and	Y 0522	• The community is committed to providing a safeenvironment for all residents, including those with a diagnosis of dementia.All direct care staff receive training on dementia care, behavior management,de-escalation techniques, and appropriate interventions to safely managesituations that may arise while maintaining each resident's dignity andwell-being. Prior to admission, every prospective resident completes aSaint Louis University Mental Status (SLUMS) examination as part of thecomprehensive assessment process. The results are used to evaluate theresidents' cognitive status and determine	01/07/2026

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	(II) The facility does not meet the requirements of NAC 449.2754 or 449.2756 or is otherwise unable to properly care for the resident. Inspector Comments: Based on record review, document review and interview, the facility failed to develop a complete person-centered service plan for a 1 of 15 sampled residents with a dementia diagnosis. Findings include: Resident #1 Resident #1 was admitted to the facility on 08/04/2023, with diagnoses including dementia and hypertension. On 01/05/2026, the service plan for Resident #1 lacked the following: -the manner in which the resident's behaviors would be managed. -the steps the facility would take to prevent the resident from wandering from the facility and how the facility would respond if the resident did so. -the criteria and provisions for the resident to be transferred or discharged from the facility if the facility did not meet the requirements to care for or were unable to property care for a resident with dementia. On 01/05/2026 at 11:46 AM, the Resident Services Director confirmed Resident #1 had a dementia diagnosis and the service plan for Resident #1 lacked specific documentation related to the resident's dementia diagnosis. Severity: 2 Scope: 1		whether the individual's needs can besafely and appropriately met within the community's scope of services. The Resident Services Director will continue to review andevaluate each resident's SLUMS score, assessment findings, and clinicalinformation before moving-in to ensure the community can safely meet theresident's needs. Ongoing assessments will be completed whenever there is asignificant change in condition to identify changes in cognition or care needs.The Resident Services Director will monitor this process on an ongoing basis toensure residents with dementia diagnosis continue to receive appropriateservices in a safe environment and that the community remains compliant withall applicable regulations.	
Y 0690 SS= D	NAC 449.2712	Y 0690	The oxygen tank was immediately secured in the appropriate storage rack upon discovery. Staff were reminded of proper	01/07/2026

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	Residents requiring use of oxygen. 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his need for oxygen; and (2) Administering the oxygen to himself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall;		oxygen tank storage procedures, and an in-service was conducted on 1/7/2026 covering: proper securing of tanks in racks, risks associated with improper storage, and a review of the community's policy and regulatory requirements. To ensure ongoing compliance, directors will conduct random weekly spot checks, and care staff have been instructed to verify the storage of all oxygen tanks while assisting residents in their apartments	

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	(6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. 3. The administrator of a residential facility shall ensure that the caregivers who may be required to administer oxygen have demonstrated the ability to operate properly the equipment used to administer oxygen. Inspector Comments: Based on record review, observation, interview, and document review, the facility failed to ensure oxygen tanks were secured for 1 of 5 resident rooms containing oxygen cylinders. Findings include: On 01/05/2026 at 11:09 AM, in Room 119, a rack held 12 e-size oxygen cylinders. An empty portable oxygen stand was parked next to the storage rack, and an e-size oxygen cylinder was sitting on the floor next to the empty portable oxygen stand. On 01/05/2026 at 11:09 AM, the Resident Services Director confirmed the oxygen cylinder was not secured and should be in a rack or stand. The facility policy, "Care Services-Oxygen Therapy," revised 07/21/2025, stated, "3. l. When not in use all oxygen cylinders should be secured in racks or stands to prevent them from tipping over." Severity: 2 Scope: 1			
Y 0878 SS= D		Y 0878	All medication carts were immediately	01/07/2026

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	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist		reviewed, and any discrepancies between medications and current physician orders were corrected, the physician was also contacted for clarification. To monitor accuracy the Resident Services Director will conduct random audits of medication carts. An in-service was completed on1/7/2026 to discuss consistency between physician orders and medications in the cart.	

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	must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, clinical record review, interview, and document review, the facility failed to ensure 1) medications were administered as prescribed for 1 of 15 residents (Resident #1) and 2) a change label was affixed to a resident's medication container following a change in the prescriber's order for 1 of 15 sampled residents (Resident #10). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/04/2023, with diagnoses including dementia and hypertension. On 01/05/2026 at 1:52 PM, the following medications were on the medication cart for Resident #20: -Vitamin B-12 2500 micrograms (mcg) tablet, take one tablet by mouth every week. Resident #1's Physician Order dated 07/26/2024 and the January 2026 Medication Administration Record (MAR), documented the following: - Vitamin B-12 5000 mcg tablet, take one tablet by mouth every week. On 01/05/2026 at 1:55 PM, the Medication Technician confirmed Resident #1's Vitamin B-12 medication on-site did not match the January 2026 MAR and physician's order.			

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	Resident #10 Resident #10 was admitted to the facility on 07/31/2022, with diagnoses including congestive heart failure and osteoarthritis. On 01/05/2026 at 1:28 PM, the following medication was one of several on the medication cart for Resident #10: -Omeprazole 40 mg Capsule, take one capsule two times daily. Resident #10's physician's order dated 06/20/2024, and the January 2026 MAR, documented the following: -Omeprazole 40 mg Capsule DR 06/25/2024-take one cap by mouth once a day (30 minutes before food). On 01/05/2026 at 1:40 PM, the Medication Technician confirmed Resident #10's Omeprazole 40 mg capsule medication on-site prescription label did not match the January 2026 MAR, and the medication was not marked with physician's change order. The facility policy titled, "Medication Administration," revised 07/21/2025, documented medication staff must compare the medication order on the Medication Administration Record to label on the medication package using the right resident, right time, right drug, right dose and right route and verify it was all correct. Severity: 2 Scope: 1			
Y 0920 SS= D	NAC 449.2748 Medication Storage. 1. Medication including, without limitation, any over-the-counter medication stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers	Y 0920	The unsecured medications referenced have been secured and the regulations have been discussed with the residents and their families. Housekeeping and Care Staff will continue to check for unlocked medications, or medications in apartments of residents that are in our medication plan and will inform the Resident Services Director or Executive Director of their findings. The Resident	01/07/2026

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	employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) medications were stored securely in a locked area inaccessible to other residents and visitors, and not in a resident's room for 3 of 15 sampled residents (Resident #1, #2 and #3); and 2) residents' medications were kept secured in the facility for 2 of 19 resident rooms with a self-administering resident (Room #201 and #231).		Services Director and Executive Director will be responsible for correcting the issue and reminding the residents and their families of the policy. To monitor compliance the Department Directors will do room checks on their manager on duty day weekly to ensure all medications are locked and properly stored in the residents' apartments. Each Department Director has been assigned certain apartments on the first and second floor. An in service to discuss proper medication storage was completed on 1/7/2026.	

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	Findings include: Resident #1 Resident #1 was admitted to the facility on 08/04/2023, with diagnoses including dementia and hypertension. Resident #1's clinical record included an Ultimate User Agreement, dated 08/04/2023, documenting the resident designated the facility's employees to possess, administer and monitor the resident's medications. On 01/05/2026 at 11:43 AM, Resident #1's room was unlocked, the resident was not present, and the following medications were found in the bathroom: -One tube of Diclofenac 1% cream. -One box of Salonpas 4% Lidocaine patches. Resident #2 Resident #2 was admitted to the facility on 10/11/2024, with diagnoses including anxiety, hyperlipidemia, and hypertension Resident #2's clinical record included an Ultimate User Agreement, dated 10/11/2024, documenting the resident designated the facility's employees to possess, administer and monitor the resident's medications. On 01/05/2026 at 11:45 AM, Resident #2's room was unlocked, the resident was not present, and the following medication was found in the bathroom: -One bottle of Pepto Bismol Resident #3 Resident #3 was admitted to the facility on 06/30/2025, with diagnoses including hyperlipidemia, anemia, and hypertension. Resident #3's clinical record included an Ultimate User Agreement, dated 06/30/2025, documenting the resident designated the facility's employees to possess, administer and monitor the			

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	resident's medications. On 01/05/2026 at 11:47AM, Resident #3's room was unlocked, the resident was not present, and the following medications were found in the bathroom: -Two bottles of Systane eye drops. On 01/05/2026 at 12:15 PM, the Resident Services Director (RSD) confirmed the unsecured medications in Resident #1, #2 and #3's room. The RSD verbalized Resident #1, #2 and #3's medications were managed by the facility. The RSD explained when the facility managed the residents' medications, the only time a resident was able to have medications in their room was if there was a physician's order to self-administer the medication. The RSD explained facility conducted room checks quarterly to ensure residents did not have unsecured medications. The facility policy titled, "Medication Control – Access Storage and Labeling of Medications," revised 07/21/2025, documented all medications were stored by the community were to be doubled locked. On 01/05/2026 the following rooms contained unsecured medications: -at 10:50 AM, in Room 201, the resident was out of the room. The corridor door was unlocked, and a key was in the medicine cabinet lock. The medicine cabinet contained various medications. -at 11:02 AM, in Room 231, the resident was out of the room. The corridor door was unlocked, the medicine cabinet was unlocked, and contained the following medications: - a bottle of potassium 99 milligrams (mg) - a bottle of omega 3 500 mg - a bottle of Equate pain reliever 500 mg On 01/05/2026 at 10:50 AM through 11:02 AM, the Resident Services Director confirmed the medications were unsecured. This was a repeat deficiency from the 10/03/2024 annual State Licensure survey.			

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	413	A. BUILDING _____ B. WING _____	01/05/2026

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	Severity: 2 Scope: 1			
Y 1010 SS= D	NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. 2. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after becoming employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. 3. As used in this section, “residential facility for persons with mental illnesses” means a residential facility that provides care and protective supervision for persons with mental illnesses, including, without limitation, schizophrenia, bipolar disorder, psychosis and other related disorders. Inspector Comments: Based on record review and interview, the facility failed to ensure employees received mental illness training within 60 days of employment for 3 of 15 sampled employees (Employee #8, #11, and #15). Findings include: On 01/05/2026 at 9:53 AM, the Executive	Y 1010	• All staff members have completed the requiredmental health training and are current with all mandated training hours inaccordance with applicable regulations and community policy. To maintain ongoing compliance, theExecutive Director will closely monitor staff training records and completiondates to ensure all required mental health training is completed within therequired timeframes. Training compliance will be reviewed on a regular basis,and any staff member approaching a renewal deadline will be scheduled tocomplete the required training prior to expiration. This ongoing monitoringprocess will help ensure continued compliance with regulatory requirements andsupport the delivery of safe, high-quality resident care.	01/14/2026

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	Director (ED) was provided the Personnel Check List to complete for 15 sampled employees. On 01/05/2026 at 3:01 PM, the ED provided the completed form, and additional information was provided via email on 01/07/2026 at 4:35 PM and 01/08/2026 at 10:52 AM, and with the following information: Employee #8 Employee #8 was hired by the facility as Resident Medication Assistant with a start date of 03/19/2025. Employee #8's record contained documented evidence of ½ hours of mental health training; however, lacked documented evidence of a total of eight hours of training in mental illness within the first 60 days of employment. Employee #11 Employee #11 was hired by the facility as Resident Medication Assistant with a start date of 02/23/2025. Employee #11's record contained documented evidence of ¾ hours of mental health training; however, lacked documented evidence of a total of eight hours of training in mental illness within the first 60 days of employment. Employee #15 Employee #15 was hired by the facility as Resident Medication Assistant with a start date of 07/17/2025. Employee #15's record contained documented evidence of ½ hours of mental health training; however, lacked documented evidence of a total of eight hours of training in mental illness within the first 60 days of employment. On 01/05/2026 at 3:01 PM, the ED provided the Attestation of Compliance form, signed and dated 01/05/2026, confirming the ED had conducted a thorough review of the personnel records to determine compliance			

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	and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			
Y 1800 SS= C	NAC 449.01065 Requirements relating to personal protective equipment; exception for nursing pool. (NRS 439.200, 439.0302) 1. A medical facility, facility for the dependent or other facility required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall ensure that each person on the premises of the facility uses personal protective equipment in accordance with the publications adopted by reference in NAC 449.0106. The facility shall maintain: (a) Not less than a 30-day supply of personal protective equipment at all times; or (b) If the facility is unable to comply with the requirements of paragraph (a) due to a shortage in personal protective equipment, documentation of attempts by and the inability of the facility to obtain personal protective equipment. 2. Except as otherwise provided in subsection 3, a medical facility, facility for the dependent or other facility required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Enter into a contract with a supplier of personal protective equipment which ensures that the facility has a supply of personal protective equipment sufficient to comply with the requirements of subsection 1; and (b) Track the amount of personal protective equipment that the facility has available, the rate at which personal protective equipment is used in the facility and orders for personal protective equipment in a manner sufficient to ensure compliance with the requirements of subsection 1.	Y 1800	Upon identification of the deficiency, the community immediately implemented a PPE tracking system to monitor inventory levels, usage, and reordering needs. A standardized PPE tracking log has been developed and put into use. The Executive Director and the Resident Services Director will review the PPE tracking log weekly to ensure compliance and accuracy. Any discrepancies or supply concerns will be addressed promptly to prevent shortages.	01/07/2026

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	Inspector Comments: Based on record review and interview, the facility failed to develop a method to track the amount of personal protective equipment (PPE) the facility had available, the rate at which personal protective equipment was used in the facility, and orders for personal protective equipment. Findings include: On 01/05/2026 at 11:07 AM, the facility lacked a method to track the PPE in the facility. On 01/05/2026 at 11:07 AM, the Resident Services Director verbalized the facility did not have a method to track the PPE available in the facility. Severity: 1 Scope: 3			
Y 1825 SS= F	**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 than 15 hours of training concerning the control and prevention of infections provided by the Association for	Y 1825	TheRegional Care Director and Resident Services Director have completed therequired training and are designated as the individuals responsible for thecommunity's infection prevention and control program. Documentation ofcompleted training has been verified and will be maintained to ensure ongoingcompliance with applicable regulatory requirements. The course has been addedto Atria Univeristy. The system will help monitor completion. A notificationwill be sent to the Resident Services Director and Regional Care director whenis time to retake the course. The National Care Director and the	03/19/2026

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	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 personnel file review and interview, the primary infection control staff lacked the required infection control training. Findings include: On 01/05/2026 at 9:53 AM, the Executive Director (ED) was provided the Personnel Check List to complete for 15 sampled employees. On 01/05/2026 at 3:01 PM, the ED provided the completed form, and additional information was provided via email on 01/07/2026 at 4:35 PM and 01/08/2026 at 10:52 AM, with the following information: Employee #16 Employee #16 was hired by the facility as National Care Director. Employee #16 had documented evidence of infection control and prevention training required for the primary infection control staff completed in 2022; however, lacked infection control and prevention training		ExecutiveDirector will be notified when the courses have been completed.	

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	completed in 2025. On 01/08/2026 at 10:52 AM, the ED sent an email stating the National Care Director was in the process of completing the 2025 training. On 01/05/2026 at 3:01 PM, the ED provided the Attestation of Compliance form, signed and dated 01/05/2026, confirming the ED had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			