STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 completed at your facility on 07/13/2026. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons. The census at the time of the survey was four. Four resident files and two employee files were reviewed. The facility received a grade of C.			
Y 0065 SS= F	**NAC 449.196 & R043-22** **Qualifications of caregivers:** 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156to 449.27706,inclusive, *and sections 2 to 16,inclusive, of this regulation* and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and *(f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a*	Y 0065	1. **How the specific findings will be corrected:**Employee #1 and Employee #2 have completed the required 8 hours of annual caregiver training (including at least 2 hours of Tier 2 training). The training documentation has been placed in both employees' personnel files. 2. **Measures or systematic changes to prevent recurrence:**A tracking system has been implemented to monitor annual caregiver training requirements for all employees. 3. **How the corrective action will be monitored:**The Administrator will conduct quarterly audits of all caregiver personnel files to ensure the 8 hours of annual training (including minimum 2 hours of Tier 2) is completed and documented timely. 4. **Person responsible:**Administrator 5. **Date corrective action will be completed:**07/15/2026 6. **Supporting documents attached:** Yes 7. **Identification of other potentially affected areas:**All other caregivers' personnel files have been reviewed to ensure they are current with annual training requirements.	07/30/2026

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	combination of tier 1 and tier 2 training related to care for the residents of the facility; and *(g)*Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training *must include, without limitation, at least 2 hours of tier 2 training.* Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 2 of 2 employees received the required eight hours of annual caregiver training (Employee #1 and #2). Findings include: Employee #1 Employee #1 was hired in 2008 as the Administrator. Employee #1's personnel record included documentation the employee completed eight hours of caregiver training in 2024. The record lacked documented evidence Employee #1 completed eight hours annual caregiver training in 2025. Employee #2 Employee #2 was hired on 03/27/2008 as the Assistant Administrator/Caregiver. Employee #2's personnel record included documentation the employee completed eight hours of caregiver training in 2024. The record lacked documented evidence Employee #2 completed eight hours annual caregiver training in 2025. On 07/13/2026 at 12:20 PM, the Administrator explained the facility completed training within the year. The Administrator confirmed Employee #1's and #2's personnel record lacked documentation of annual caregiver training completed in 2025. Severity: 2 Scope: 3			

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Y 0074 SS= D	1. An applicant for a license to operate a facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day, residentialfacility for groups or home for individual residential care must receivetraining to recognize and prevent the abuse of older persons before a licenseto operate such a facility, agency or home is issued to the applicant. If anapplicant has completed such training within the year preceding the date of theapplication for a license and the application includes evidence of thetraining, the applicant shall be deemed to have complied with the requirementsof this subsection. 2. A licensee who holds alicense to operate a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home for individualresidential care must annually receive training to recognize and prevent theabuse of older persons before the license to operate such a facility, agency orhome may be renewed. 3. If an applicant orlicensee who is required by this section to obtain training is not a naturalperson, the person in charge of the facility, agency or home must receive thetraining required by this section. 4. An administrator or otherperson in charge of a facility for intermediate care, facility for skillednursing, agency to provide personal care services in the home, facility for thecare of adults during the day, residential facility for groups or home forindividual residential care must receive training to recognize and prevent theabuse of older persons before the facility, agency or home provides care to aperson and annually thereafter. 5. An employee who willprovide care to a person in a facility for intermediate care,	Y 0074	**Plan of Correction 2: Annual Elder Abuse Training** 1. How the specific findings will be corrected:Employee #2 has completed the required annual training to recognize and prevent the abuse of older persons. The training documentation has been placed in Employee #2's personnel file. 2. Measures or systematic changes to prevent recurrence:Elder abuse training has been incorporated into the facility's overall staff training tracking system with clear due dates based on each employee's anniversary date. 3. How the corrective action will be monitored:The Administrator will conduct quarterly audits of all personnel files to ensure every employee who provides care has current annual elder abuse training documentation. 4. Person responsible:Administrator 5. Date corrective action will be completed:07/15/2026 6. Supporting documents attached:Yes 7. Identification of other potentially affected areas:All other employees' personnel files have been reviewed to confirm they have current elder abuse training documentation.	07/26/2026

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	facility forskilled nursing, agency to provide personal care services in the home, facilityfor the care of adults during the day, residential facility for groups or homefor individual residential care must receive training to recognize and preventthe abuse of older persons before the employee provides care to a person in thefacility, agency or home and annually thereafter. 6. The topics of instructionthat must be included in the training required by this section must include,without limitation: (a) Recognizing the abuse ofolder persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; (b) Responding to reports ofthe alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091to 200.50995,inclusive; and (c) Instruction concerning thefederal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agenciesto provide personal care services in the home, facilities for the care ofadults during the day, residential facilities for groups or homes forindividual residential care, as applicable for the person receiving thetraining. 7. The facility forintermediate care, facility for skilled nursing, agency to provide personalcare services in the home, facility for the care of adults during the day,residential facility for groups or home for individual residential care isresponsible for the costs related to the training required by this section. 8. The administrator of afacility for intermediate care, facility for skilled nursing or residentialfacility for groups who is licensed pursuant to chapter 654 ofNRS shall ensure that each employee of the			

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	facility who provides care toresidents has obtained the training required by this section. If anadministrator or employee of a facility or home does not obtain the trainingrequired by this section, the Division shall notify the Board of Examiners forLong-Term Care Administrators that the administrator is in violation of thissection. 9. The holder of a license tooperate a facility for intermediate care, facility for skilled nursing, agencyto provide personal care services in the home, facility for the care of adultsduring the day, residential facility for groups or home for individualresidential care shall ensure that each person who is required to comply withthe requirements for training pursuant to this section complies with suchrequirements. The Division may, for any violation of this section, takedisciplinary action against a facility, agency or home pursuant to NRS 449.160and 449.163. Inspector Comments: Based on personnel record review and interview, the Administrator failed to ensure annual elder abuse training was completed timely for 1 of 2 employees (Employee #2). Findings include: Employee #2 Employee #2 was hired on 03/27/2008 as the Assistant Administrator/Caregiver. Employee #2's personnel record included documentation of elder abuse training was completed on 08/19/2024 and 05/12/2026. The record lacked documented evidence of elder abuse training completed in 2025. On 07/13/2026 at 12:20 PM, the Administrator explained the facility completed training within the year. The Administrator confirmed Employee #2's personnel record lacked documented evidence elder abuse training was completed in 2025.			

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	Severity : 2 Scope : 1			
Y 0106 SS= D	**NAC 449.0113 and R089-24** 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform 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 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.	Y 0106	How the specific findings will be corrected:Employee #1 has completed current CPR and First Aid certification on 07/15/2026. The current certificate has been placed in Employee #1's personnel file. Measures or systematic changes to prevent recurrence:CPR and First Aid certification expiration dates have been added to the facility's staff training tracking system with reminders set prior to expiration. How the corrective action will be monitored:The Administrator will conduct quarterly audits of all personnel files to ensure all required staff maintain current CPR and First Aid certification at all times. Person responsible:Administrator Date corrective action will be completed:07/15/2026 Supporting documents attached:Yes Identification of other potentially affected areas:All other employees' personnel files have been reviewed to ensure current CPR and First Aid certifications are in place.	07/15/2026

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	Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) retraining was completed for 1 of 2 employees (Employee #1). Findings include: Employee #1 Employee #1 was hired in 2008 as the Administrator. Employee #1's personnel record included CPR training completed in 06/2024, valid for two years. The record lacked documented evidence of current CPR training. On 07/13/2026 at 12:34 PM, the Administrator confirmed the CPR training for Employee #1 was expired. Severity: 2 Scope: 1			
Y 0872 SS= D	NAC 449.2742 **Administration of medication: Responsibilities of administrator.** (f) In his or her first year of employment as an administrator of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training. (g) After receiving the initial training required by paragraph (f), receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of	Y 0872	How the specific findings will be corrected:Employee #1 completed the required medication management training on 06/30/2026. The certificate has been placed in Employee #1's personnel file. Measures or systematic changes to prevent recurrence:Medication management training and certificate expiration dates have been added to the facility's staff training tracking system with reminders scheduled 30–60 days before expiration. How the corrective action will be monitored:The Administrator will conduct quarterly audits of all personnel files for staff who administer medications to ensure current medication management training certificates are present and valid. Person responsible:Administrator Date corrective action will be completed:07/15/2026 Supporting documents attached:Yes	07/15/2026

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	the training and his or her attendance at the training. (h) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure the annual medication management training was completed timely for 1 of 2 employees administering medication (Employee #1). Findings include: Employee #1 Employee #1 was hired in 2008 as the Administrator. Employee #1's personnel record documented Employee #1 completed eight hours of medication management training on 04/24/2025 and the certificate had an expiration date of 04/24/2026. The record documented medication management 16-hour training completed 06/30/2026. The annual medication management training was completed two months late. On 07/13/2026 at 12:40 PM, the Administrator verbalized medication management was to be completed yearly. The Administrator confirmed having passed medications after the certificate expired. The Administrator confirmed medication management was completed late and completed the 16-hour course. Severity: 2 Scope: 1		Identification of other potentially affected areas:All other employees who administer or assist with medications have been reviewed to ensure they have current medication management training.	
Y 0960 SS= D	NAC 449.2754 Residential facility which provides care	Y 0960	How the specific findings will be corrected:The physician corrected the determination for Resident #3 on 08/04/2026 after confirming the original marking was made in error. The corrected physician determination no longer requires	08/04/2026

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	to persons with Alzheimer's disease: Application for endorsement; general requirements. 1. A residential facility which offers or provides care for a resident with Alzheimer's disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer's disease. 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. Inspector Comments: Based on record review and interview, the facility failed to obtain an Alzheimer's/dementia endorsement to provide care to residents with Alzheimer's disease or related dementia for 1 of 4 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 02/14/2026, with diagnosis of senile degeneration of the brain. The determination of the physician, dated 02/18/2026, indicated the resident required a facility endorsed for the care of Alzheimer's related diagnosed residents. On 07/13/2026 at 1:39 PM, the Assistant Administrator explained being responsible for reviewing the forms and had not noticed the physician marked the resident was in need a facility endorsed to care for Alzheimer's or related conditions. The Assistant Administrator verbalized the facility was not endorsed for Alzheimer's and dementia. Severity: 2 Scope: 1		an Alzheimer's/dementia endorsed facility. The corrected document has been placed in Resident #3's record. Measures or systematic changes to prevent recurrence:All physician determination forms will be carefully reviewed upon admission to identify any requirement for an Alzheimer's/dementia endorsement. How the corrective action will be monitored:The Administrator will conduct quarterly audits of all new admissions to ensure physician determinations are properly reviewed for Alzheimer's/dementia endorsement requirements. Person responsible:Administrator Date corrective action will be completed:08/04/2026 Supporting documents attached:Yes Identification of other potentially affected areas:All current resident records have been reviewed to ensure no other resident requires an Alzheimer's/dementia endorsement.	

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Y 1600 SS= C	**NAC 449.011943 and R004-24** **NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104)** 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses	Y 1600	**Plan of Correction 5: Resident Identity Documentation (Preferred Pronoun, Gender Identity & Sexual Orientation)** 1. How the specific findings will be corrected:A standardized form documenting each resident's preferred pronoun, gender identity or expression, and sexual orientation has been completed and placed in the records of Residents #1, #2, #3, and #4 on 07/13/2026. 2. Measures or systematic changes to prevent recurrence:A new "Resident Identity & Preferred Pronoun" form has been created and added to the admission packet. This form will be completed for every resident upon admission and updated as needed. 3. How the corrective action will be monitored:The Administrator will conduct quarterly audits of all active resident records to ensure the Resident Identity form is present and completed. 4. Person responsible:Administrator 5. Date corrective action will be completed:07/13/2026 6. Supporting documents attached:Yes 7. Identification of other potentially affected areas:All current resident records have been reviewed and the required documentation has been completed for every resident.	07/15/2026

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	to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection1, include, without limitation: (a) The preferred name and pronoun ofthe patient or resident; (b) The gender identity or expressionof the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be			

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	present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 4 resident records included documentation of residents' preferred pronoun, gender identity or expression and sexual orientation (Resident #1, #2, #3, and #4). Findings include: On 07/13/2026, Residents #1, #2, #3, and #4's records lacked documentation of residents' preferred pronoun, gender identity or expression and sexual orientation. On 07/13/2026 at 1:56 PM, the Administrator confirmed Residents #1, #2, #3, and #4's records had not been adapted to include the residents' preferred pronoun, gender identity or expression and sexual orientation. Severity : 1 Scope : 3			
Y 1700 SS= E	**NRS 449.1845** **Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement**	Y 1700	• **Plan of Correction 7: Placement Assessment and Determination** i. How the specific findings will be corrected:The Placement Assessment and Determination for Resident #1 has been properly dated and completed. The 2026 annual Placement Assessment and	08/04/2026

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WHISPERING HEIGHTS	2397 EMPIRE RANCH ROAD, CARSON CITY, NEVADA ,89701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed.		Determination for Resident #4 has also been completed. Both documents have been placed in the respective resident records. ii. Measures or systematic changes to prevent recurrence:A standardized Placement Assessment form will be used for all admissions. Annual assessments will be scheduled according to each resident's admission anniversary date and tracked on a Resident Assessment Log. iii. How the corrective action will be monitored:The Administrator will conduct quarterly audits of all resident records to ensure both initial and annual placement assessments are completed, dated, and properly documented. iv. Person responsible:Administrator v. Date corrective action will be completed:07/15/2026 vi. Supporting documents attached:Yes vii. Identification of other potentially affected areas:All current resident records have been reviewed to ensure initial and annual placement assessments are completed and current.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the Administrator			

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	failed to ensure a placement assessment determination was completed upon admission to the facility for 1 of 5 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 02/24/2026, with diagnoses including gait instability, hypothyroid, and acute respiratory failure. Resident #1's record documented a placement assessment and determination prior to or upon admission to the facility; however, was undated. Resident #4 Resident #4 was admitted to the facility on 03/28/2025, with diagnoses including Alzheimer's disease, hyperlipidemia and anemia. Resident #4's record documented an initial placement assessment and determination dated 04/23/2025; however, Resident #4's record lacked documentation of a placement assessment and determination completed in 2026. On 07/13/2026 at 2:44 PM, the Assistant Administrator verbalized the placement assessment and determination for Resident #1 was undated and not a completed document. The Assistant Administrator confirmed an annual placement assessment and determination was not completed for 2026 for Resident #4. Severity: 2 Scope: 2			
Y 1810 SS= C	**NAC 449.0109** **Program and policy for control of infection; designation and training of person responsible for infection control. (NRS439.200, 449.0302)**	Y 1810	**Plan of Correction 6: Infection Control Plan & Emergency Preparedness Plan** 1. How the specific findings will be corrected:The Infection Prevention and Control Plan was reviewed on 07/13/2026 and an annual review	07/15/2026

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	1. A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and control infections within the facility; (b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; and (c) Develop and carry out a comprehensive plan for emergency preparedness. 2. To carry out the infection control program developed pursuant to paragraph (a) of subsection 1, the facility shall adopt an infection control policy. The policy must include, without limitation, current infection control guidelines developed by a nationally recognized infection control organization that are appropriate for the scope of service of the facility. Such nationally recognized organizations include, without limitation, 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. 6. The plan for emergency preparedness developed pursuant to paragraph (c) of subsection 1 must address internal and external emergencies and local and widespread emergencies. Such emergencies must include, without limitation, emerging infectious diseases. Inspector Comments: Based on observation, document review and interview, the Administrator failed to 1) ensure the facility's Infection Control		log page was added documenting the review. An Emergency Preparedness Plan was developed and implemented on 07/13/2026. 2. Measures or systematic changes to prevent recurrence:Both the Infection Prevention and Control Plan and the Emergency Preparedness Plan have been added to the facility's annual policy review calendar. 3. How the corrective action will be monitored:The Administrator will conduct quarterly audits to ensure both plans have current annual review documentation and are being reviewed at least once every 12 months. 4. Person responsible:Administrator 5. Date corrective action will be completed:07/13/2026 6. Supporting documents attached:Yes 7. Identification of other potentially affected areas:All other required facility policies have been reviewed to ensure they also have current review documentation.	

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	Program was reviewed annually and 2) developed an emergency preparedness plan. Findings include: On 07/13/2026 at 1:46 PM, the facility's Infection Prevention and Control Plan, undated, was provided by the Administrator. The Infection Prevention and Control Plan lacked documented evidence the plan was reviewed annually. The facility lacked documented evidence of an emergency preparedness plan. On 07/13/2026 at 2:00 PM, the Administrator verbalized not being sure how often the Infection Control Plan and policies were to be reviewed. The Administrator confirmed the facility's Infection Prevention and Control Plan lacked documented evidence of being reviewed annually and the facility lacked an emergency preparedness plan. Severity:1 Scope: 3			