STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
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 a complaint investigation, and annual survey completed at your facility on 10/08/2025. The facility is licensed for 120 Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, and/or 30 Alzheimer's disease, Category II residents. The census at the time of the survey was 106. Twenty-five resident files and twenty employee files were reviewed. The facility received a grade of D. There was one complaint investigated. Complaint #12247 was substantiated. (See Tag Y0250) The following regulatory deficiencies were identified:			
Y 0100 Z SS= D	Personnel files. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; Records relating to the training received by the employee including, without limitation: (1) Certificates of completion for all training	Y 0100 Z	**Personnel Files for Contract Labor Employees** 1) How you will correct the specific finding(s) stated in the SOD? By 1/15/26, Facility will obtain personnel records for any contract labor employees working in the facility. Employee #'s 21 & 23 are no longer working at the facility. 2) What measures will be put into place to ensure the deficient practice does not recur? Any future contract employees who come to work at the Facility will be required to bring their personnel file with them on their first day of work. 3) How the corrective action(s) will be	01/15/2026

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	completed by the employee; and (2) If a tier 2 training is not provided through a course listed on the Internet website maintained by the Division pursuant to subsection 2 of section 7 of this regulation, a list of topics covered by the training which may consist of, without limitation, the syllabus for the training or an outline of the training; Evidence that the references supplied by the employee were checked by the residential facility Inspector Comments: Based on observation and interview, the facility failed to ensure 3 of 23 sampled employees had a personnel file. Findings include: On 10/08/2025/2025 at 10:38 AM, the Dining Services Director explained two of the staff in the kitchen this day were contracted staff and had only been working in the facility for a few days. On 10/08/2025 at 10:00 AM, the Administrator was asked for a list of all contracted staff who worked in the facility. On 10/08/2025 at 12:15 PM, the Business Office Manager was asked for the employee files for three contracted staff. On 10/08/2025 at 2:53 PM, the Administrator confirmed there was no employee files for contracted staff. On 10/08/2025 at 3:17 PM, the Business Office Manager confirmed there were no employee files for Employees #21, #22, and #23 and they needed to have a full employee file as all employees which included, name, address, telephone number, social security number, date of hire and all applicable training for the employees' position.		monitored? Business Office Manager and/or designee will monitor all contract labor employees to ensure personnel records are on file at the Facility. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Business Office Manager 5) The date the corrective action will be completed? 1/15/2026	

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	Severity: 2 Scope: 1			
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. 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, interview and document review, the facility failed to ensure the ice machine was maintained, kitchen floor was cleaned, sanitizer solution had the required level of sanitizer, a kitchen employee wore a hairnet or hair covering	Y 0250	**NAC449.2171 - Kitchen** **Ice Machine** 1) How you will correct the specific finding(s) stated in the SOD? The entire bottom seal for the main compartment of the ice machine was replaced by a contractor prior to 11/14/2025. 2) What measures will be put into place to ensure the deficient practice does not recur? The new door seal should remain flexible and intact for the foreseeable future. 3) How the corrective action(s) will be monitored? The Dining Services Director or Designee will inspect the bottom seal of the ice machine weekly to ensure it is fully intact and provides a good seal for the door. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Dining Services Director 5) The date the corrective action will be completed? 11/14/2025. **Kitchen Floor** 1) How you will correct the specific finding(s) stated in the SOD? The onion rings observed on the floor were removed and placed in the trash immediately following the observation.	11/24/2025

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	while in the kitchen, a refrigerator temperature log had been completed, and stored food had been dated upon receiving. Findings include: Ice Machine On 10/08/2025 at 9:34 AM, the bottom seal for the lid was missing from the ice machine located in the kitchen. The front of the machine had the top and sides of the lid seal intact, but the bottom seal was torn from both sides and was missing. The ice machine lid could not be closed completely. On 10/08/2025 at 9:35 AM, the Dining Services Director confirmed the seal had been broken and was missing from the ice machine. The Dining Services Director verbalized not having been sure if the Maintenance Department had been made aware of the broken seal. On 10/08/2025 at 10:03 AM, the Executive Director confirmed no work order for the broken ice machine seal had been submitted to the Maintenance Department. On 10/08/2025 at 1:41 PM, the Dining Services Director verbalized the ice machine seal had been broken and missing for the previous 4 to 5 months and the Dining Services Director confirmed not having placed the work order with the Maintenance Department or informing anyone of the needed repair. Kitchen Floor On 10/08/2025 at 9:32 AM, two fried onion rings were observed on the kitchen floor in front of the deep fryer.		Later that same day the kitchen floor was swept and mopped by the Kitchen Utility. 2) What measures will be put into place to ensure the deficient practice does not recur? On 11/24/2025, the floor cleaning procedure and schedule was finalized and implemented. The floor cleaning procedure includes Kitchen Utility sign-off in the log book each time the procedure is completed. 3) How the corrective action(s) will be monitored? Dining Services Director observes the kitchen floors daily for cleanliness. Dining Services Directors also observes the cleaning logs to ensure ongoing compliance with the procedure. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Dining Services Director 5) The date the corrective action will be completed? 11/24/2025 **Sanitizer Solution** 1) How you will correct the specific finding(s) stated in the SOD? Immediately following observation by the Surveyor the sanitizer buckets were emptied and refilled with water and sanitizer solution at the correct concentration. 2) What measures will be put into place to ensure the deficient practice does not recur? Kitchen Utility Staff were trained on 10/8/2025 on the correct procedure to fill the sanitizer buckets to the correct concentration. EcoLab serviced the sanitizer dispenser on 10/10/2025 and adjusted the output to ensure correct	

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	On 10/08/2025 at 9:39 AM, the Dining Services Director verbalized kitchen staff were to sweep and mop the kitchen floors after each lunch and dinner meal, and verbalized onion rings were served to residents the day before. On 10/08/2025 at 9:40 AM, the Dining Services Director confirmed the floors in the kitchen had not been swept or mopped as there were two onion rings from the previous day's meal on the floor in front of the fryer. Sanitizer Solution On 10/08/2025 at 9:28 AM, the sanitizer in the bucket located on the trayline was tested by the Dining Services Director for the required amount of sanitizer with a pH (potential for hydrogen) test strip. The Dining Services Director verbalized the result of the test strip showed the bucket did not contain enough sanitizer. On 10/08/2025 at 9:29 AM, the sanitizer in the bucket located next to the hand washing station was tested by the Dining Services Director for the required amount of sanitizer with a pH test strip. The Dining Services Director verbalized the result of the test strip showed the bucket did not contain enough sanitizer. On 10/08/2025 at 9:31 AM, the sanitizer in the bucket located at the First Serving Station was tested by the Dining Services Director for the required amount of sanitizer with a pH test strip. The Dining Services Director verbalized the result of the test strip showed the bucket did not contain enough sanitizer. On 10/08/2025 at 2:54 PM, the Executive Director verbalized the facility did not have a policy on the required level of sanitizer for		concentration in the sanitizer buckets. 3) How the corrective action(s) will be monitored? Sanitizer buckets are tested 3 times daily to ensure correct concentration. Results are documented in the sanitizer bucket log-book. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Dining Services Director 5) The date the corrective action will be completed? 10/10/2025 **Hairnet/Hair Covering** 1) How you will correct the specific finding(s) stated in the SOD? Employee#21 donned a hairnet after the observation was made. 2) What measures will be put into place to ensure the deficient practice does not recur? Employee #21 was working for the contract agency and we asked that he not return. Dining Services Director ensures that all new employees in the kitchen are provided hats and/or hair nets for hair retention. 3) How the corrective action(s) will be monitored? Dining Services Director and Designee monitor employees in the kitchen daily to ensure proper hair retention at all times. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Dining Services Director 5) The date the corrective action will be completed? 10/8/2025	

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	the kitchen. Hairnet/Hair Covering On 10/08/2025 at 10:38 AM, Employee #21 was working in the kitchen's dishwashing area. The employee was not wearing a hairnet or hair covering. On 10/08/2025 at 10:39 AM, the Dining Services Director confirmed Employee #21 had been working in the kitchen without a hair net, as the Dining Services Director had asked Employee #21 to wear a hair covering previously, but the employee did not. The facility policy titled, "Food and Dining Policies and Procedures Manual," revised 11/2014, documented the appropriate work attire for kitchen staff included hair must be restrained and a hat or hairnet must be worn. Refrigerator Temperature Log On 10/08/2025 at 10:36 AM, the temperature log hanging on the front of the small refrigerator located in the First Serving Station, documented the last recorded temperature was on 10/04/2025. On 10/08/2025 at 10:42 AM, the Dining Services Director confirmed the temperature for the small refrigerator located in the First Serving Station had not been completed since 10/04/2025 even if it is required to be recorded daily. The facility policy titled, "Food and Dining Policies and Procedures Manual," revised 11/2014, documented cooler and freezer temperatures would be checked and recorded daily.		**Refrigerator Temperature Log** 1) How you will correct the specific finding(s) stated in the SOD? During survey observation, Dining Services Director observed the temperature in the small refrigerator and documented that on the temperature log. 2) What measures will be put into place to ensure the deficient practice does not recur? Documenting refrigerator temperature in the log book was added to the Server responsibilities in their side work assignment book. 3) How the corrective action(s) will be monitored? Dining Services Director and Designee monitor refrigerator temperature logs daily to ensure proper documentation of temperatures from the day before. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Dining Services Director 5) The date the corrective action will be completed? 10/10/2025 **Food Labeling** 1) How you will correct the specific finding(s) stated in the SOD? Starting for the next food delivery following the survey date, Cooks were instructed to write the delivery date on each item as they stock the items on the shelves. 2) What measures will be put into place to ensure the deficient practice does not recur? All Cooks were each issued multiple	

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	Food Labeling On 10/08/2025 at 9:42 AM, all unopened food items stored in the walk-in cooler and the dry storage lacked dating when the items had been received. On 10/08/2025 at 9:43 AM, the Dining Services Director confirmed only prepared foods, and leftover foods were dated when stored. The Dining Services Director verbalized having been unsure if all food items were required to be dated when they were received. On 10/08/2025 at 3:40 PM, the Dining Services Director verbalized having reviewed the facility policy and confirmed should have been dating all food items when they were received. The facility policy titled, “Food and Dining Policies and Procedures Manual-Food Storage,” revised 11/2014, documented all food items were to be dated upon receipt with the month, day and year. Complaint #12247 Severity: 2 Scope: 3		permanent markers and trained on the correct way to label items. 3) How the corrective action(s) will be monitored? Dining Services Director and Designee will monitor food storage areas daily to ensure new orders that have recently been stocked are properly dated with the delivery date. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Dining Services Director 5) The date the corrective action will be completed? 10/11/2025	
Y 0690 SS= D	**NAC 449.2712** **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:	Y 0690	**NAC449.2712 – Oxygen Tank Storage** 1) How you will correct the specific finding(s) stated in the SOD? The unsecured oxygen tank was immediately secured by the Wellness Director in the designated oxygen storage rack on 10/8/2025. The resident’s oxygen use and storage requirements were reviewed by the	12/31/2025

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	(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; (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		Wellness Director to ensure compliance with safety standards. 2) What measures will be put into place to ensure the deficient practice does not recur? Nevada Admin Code 449.2712 was posted in the Wellness Center on10/13/25. Staff received re-education on oxygen storage and safety requirements during the Wellness Department meeting on 10/25/25, in accordance with NAC449.2712. 3) How the corrective action(s) will be monitored? Weekly inspections of oxygen storage areas will be conducted for 60days. Results will be reviewed during Quality Assurance meetings. Monitoring logs have been maintained beginning 10/17/25. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Wellness Director and/or Designee 5) The date the corrective action will be completed? 12/31/2025	

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	(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 1) oxygen tanks were secured for 1 of 11 residents with oxygen cylinders. Findings include: On 10/08/2025 at 11:42 AM, in Room 391, two B-sized oxygen cylinders were on the floor of the closet. On 10/08/2025 at 11:42 AM, the Wellness Director confirmed the oxygen cylinders were not secured and should be in a rack. Severity: 2 Scope: 1			
Y 0850 SS= D	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.**	Y 0850	NAC449.274 - Annual Health & Physical (H&P) Examination 1) How you will correct the specific finding(s) stated in the SOD? The annual physical examination for Resident #2 was due on 7/21/25 & completed on 8/9/25 following physician	12/31/2025

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	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 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		scheduling limitations. Required documentation was finalized on 8/12/25. 2) What measures will be put into place to ensure the deficient practice does not recur? A tracking system for Physician Plans of Care and H&Ps is in place. Notifications will now occur 60 days prior to expiration. 3) How the corrective action(s) will be monitored? Monthly review of due dates with compliance reporting to the Executive Director. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Wellness Director and Memory Care Director or Designee 5) The date the corrective action will be completed? 12/31/2025	

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	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 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 record review and interview, the facility failed to ensure a physical examination was completed annually for 1 of 25 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 07/23/2024, with diagnoses including dementia, atrial fibrillation, and insomnia.			

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	5232	A. BUILDING _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

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	Resident #2's record documented a general physical exam with a review of systems dated 07/21/2024. Resident #2's record documented a general physical exam with a review of systems was completed on 08/12/2025, 22 days late. On 10/08/2025 at 1:56 PM, the Memory Care Director confirmed Resident #2's annual physical examinations were performed late and are expected to be completed annually, in a timely manner. Severity: 2 Scope: 1			
Y 0878 SS= D	**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	Y 0878	**NAC449.27425 – Medication Label Matching the Physician's Order** 1) How you will correct the specific finding(s) stated in the SOD? All cited medication issues were corrected through medication delivery, discontinuation, destruction when applicable, and reconciliation of labels with physician orders and eMAR system. All discrepancies were resolved by the dates noted, and medications for deceased residents were appropriately destroyed. **Resident#2**:Daughter was contacted about providing more Ensure Original Liquid Vanilla Drink for PRN order. It was delivered on 10/10/25. **Resident#11**:C-PDR cream was delivered on 10/14/25 and then discontinued on 11/1/25.Docusate Sodium was discontinued on 10/14/25. Lorazepam concentrate 2mg/ml showed every 4 hours on label and every 30 minutes in eMAR. Change order sticker was applied to medication bottle. This resident passed 11/13/25 and all medications were removed from	03/31/2026

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	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 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) physician ordered medications were on site and available to be administered for 3 of 25 sampled residents (Resident #2, #11 and #15), 2) a medication label matched the physician's order for 1 of 25 sampled residents (Resident #11), and 3) 1of 25 sampled residents' (Resident #13) clinical record included documentation of a physician, physician assistant, advanced practice registered nurse, registered nurse, or pharmacist having reviewed and interpreted a prescription when the pharmacy-prepared label on a medication did not match the		the cart and destroyed. **Resident#13**Memory Care Director corrected eMAR on 10/8/25 to reflect the correct administration times of 7A, 11A, 2P, 6P. **Resident #15**: Nystatin Powder was discontinued on 10/8/25. 2) What measures will be put into place to ensure the deficient practice does not recur? Medication Technicians were retrained on 10/25/25 regarding medication availability, label verification, and alignment with physician orders and eMAR documentation. Medication Technicians are responsible for verification prior to administration. Nurses are responsible for verification prior to approving medication in eMAR. 3) How the corrective action(s) will be monitored? Weekly medication cart audits, including PRN stock and expiration checks, will be conducted for 90 days by Nurses, Wellness Director, Memory Care Director and/or Designee. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Nurses, Wellness Director, Memory Care Director and/or Designee 5) The date the corrective action will be completed? 3/31/2026	

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	physician's order. Findings include: On Site Resident #2 Resident #2 was admitted to the facility on 07/23/2024, with diagnoses including dementia, atrial fibrillation, and insomnia. Resident #2's clinical record included physician's orders, dated 01/08/2025, documenting the following: -Ensure Original Liquid Vanilla. Drink 1 bottle by mouth three times a day as needed for nutritional supplement. Resident #2's October 2025 Medication Administration Record (MAR) documented the following: -Ensure Original Liquid Vanilla. Drink 1 bottle by mouth three times a day as needed for nutritional supplement. On 10/08/2025 at 2:36 PM, during a review of Resident #2's medications and in the presence of a Medication Technician (MT), the following was observed: -Ensure was not present among Resident #2's medications. Resident #11 Resident #11 was admitted to the facility on 10/24/2023, with diagnoses including hypothyroidism, insomnia, and atrial fibrillation. Resident #11's clinical record included physician's orders, dated 05/14/2025, documenting the following: -C-PDR 25/2/10 milligram (mg)/ gram (gm) cream. Apply one pump topically to inner			

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	forearm every six hours as needed for nausea or vomiting. -Docusate Sodium capsule 100 mg. Take one capsule by mouth once daily as needed for constipation. Resident #11's October 2025 MAR documented the following: -C-PDR 25/2/10 mg/gm cream. Apply one pump topically to inner forearm every six hours as needed for nausea or vomiting. -Docusate Sodium capsule 100 mg. Take one capsule by mouth once daily as needed for constipation. On 10/08/2025 at 1:37 PM, during a review of Resident #11's medications and in the presence of MT 1, the following was observed: -C-PDR cream was not present among Resident #11'smedications. -Docusate Sodium was not present among Resident #11'smedications. On 10/08/2025 at 1:37 PM, the MT 1 verbalized all ordered medications should be onsite and able to be administered in case a resident needed it. The MT 1 confirmed Resident #11's C-PDR cream and Docusate Sodium were not present among Resident #11's medications. Resident #15 Resident #15 was admitted to the facility on 06/22/2021, with diagnoses including chronic pain, urinary incontinence, and mild cognitive impairment. Resident #15's clinical record included a			

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	physician's orders, dated 05/14/2025, documenting Nystatin Powder 100000. Apply topically to peritoneal area, groin, abdominal folds, or under breast area three times a day as needed for skin irritation, rash, or redness. Resident #15's October 2025 MAR documented Nystatin Powder 100000. Apply topically to peritoneal area, groin, abdominal folds, or under breast area three times a day as needed for skin irritation, rash, or redness. On 10/08/2025 at 1:17 PM, during a review of Resident #15's medications and in the presence of MT 1, a medication label documented Nystatin Powder100000. Apply topically to peritoneal area, groin, abdominal folds, or under breast area three times a day as needed for skin irritation, rash, or redness. On 10/08/2025 at 1:17 PM, the MT 1 verbalized Nystatin Powder was used to address Resident #15's skin irritation and confirmed the Nystatin Powder was not present among the resident's medications but should have been. Medication Label Resident #11 Resident #11 was admitted to the facility on 10/24/2023, with diagnoses including hypothyroidism, insomnia, and atrial fibrillation.			

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	Resident #11's clinical record included a physician's order, dated 05/14/2025, documenting Lorazepam concentrate 2 mg/milliliter (mL). Take0.25 mL by mouth every 30 minutes as needed for anxiety, agitation, or restlessness related to pain. Hospice may titrate. Resident #11's October 2025 MAR documented Lorazepam concentrate 2 mg/mL. Take 0.25 mL by mouth every 30minutes as needed for anxiety, agitation, or restlessness related to pain. Hospice may titrate. On 10/08/2025 at 1:45 PM, during a review of Resident #11's medications and in the presence of an MT 1, a medication label documented Lorazepam concentrate2 mg/mL. Take 0.25 mL by mouth every four hours as needed for anxiety, agitation, or restlessness related to pain. On 10/08/2025 at 1:37 PM, the MT 1 verbalized the MAR and medication label should match the physician's order to ensure the correct medication dose was administered. The MT 1 confirmed the Lorazepam medication label documented every four hours while the MAR documented every 30 minutes. Resident #13 Resident #13 was admitted to the facility on 05/31/2025, with a diagnosis of Parkinson's disease. Resident #13's October 2025, Medication Administration Record (MAR) documented Carbidopa-Levodopa Extended Release (ER) 50-200 milligrams (mg). Take one tablet by mouth four times daily at 7:00 AM, 11:00 AM, 2:00 PM, and 6:00 PM for Parkinson's. The scheduled administration times on the MAR were 7:00 AM, 12:00 PM, 2:00 PM, and 6:00 PM.			

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	A Physician's Order dated 09/23/2025, documented Carbidopa-Levodopa ER 50-200 mg, take one tablet by mouth four times daily at 7:00 AM, 11:00 AM, 2:00 PM, and 6:00 PM for Parkinson's. Schedule: daily at 8:00 AM, 12:00 PM, 2:00 PM, and 6:00 PM. Resident #13's clinical record lacked documented evidence of a review and interpretation of the prescription for Carbidopa-Levodopa completed by a physician, physician assistance, advanced practice registered nurse, registered nurse, or pharmacist. On 10/08/2025 at 2:33 PM, during a review of Resident #13's medications and in the presence of a Medication Technician (Med Tech), a bubble pack containing Carbidopa-Levodopa 50-200 mg tablets was observed. The pharmacy-prepared label included instructions to take one tablet by mouth daily at 7:00 AM, 11:00 AM, 2:00 PM, and 6:00 PM. The Med Tech acknowledged the scheduled times on the label and the facility's MAR did not match. On 10/08/2025 at 2:42 PM, the Memory Care Director (MCD) confirmed the scheduled administration times on Resident #13's October 2025 MAR did not match the administration times on the physician's order. The MCD verbalized the MCD was unsure if the facility had received an updated or clarified physician's order, would have to look in the resident's record, and would provide the State Agency with a copy of the physician's order if a clarification had been obtained. Upon conclusion of the survey, the MCD had not provided the SA with any additional orders or documentation related to Resident #13's Carbidopa-Levodopa. The facility policy titled "Medication Assistance," revised 10/2023, documented it was the responsibility of the licensed personnel to contact the resident's health care provider with any questions, concerns or observations related to administered medications.			

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	Severity: 2 Scope: 1			
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. (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	Y 0930	**NAC449.2749 – Initial & Annual Activities of Daily Living (ADL) Assessment** 1) How you will correct the specific finding(s) stated in the SOD? Resident#20's record was reviewed and confirmed compliant. All required assessments were completed and properly documented. Resident#20 has initial assessment 1/25/24, a 3-month assessment on 3/14/24 and additional assessments on 10/15/24, 4/13/25 and 10/5/25. These assessments are in the resident chart and are in compliance. 2) What measures will be put into place to ensure the deficient practice does not recur? No corrective action required. 3) How the corrective action(s) will be monitored? Ongoing monitoring via PointClickCare according to assessment schedule. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Wellness Director, Memory Care Director, and/or Designee 5) The date the corrective action will be completed? 12/23/2025	12/23/2025

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	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 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			

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	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 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			

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	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 an initial and annual Activities of Daily Living (ADL's) assessment was completed timely for 1 of 20 sampled residents (Resident #20). Findings include: Resident #20 Resident #20 was admitted to the facility on 01/26/2024, with diagnoses including essential hypertension, unspecified dementia, and left knee osteoarthritis. Resident #20's clinical record documented an initial ADL assessment on 01/25/2024. Resident #20's clinical record documented an annual ADL assessment on 10/05/2025, eight months late. On 10/07/2025 at 1:37 PM, the Wellness Director confirmed the annual ADL assessment for Resident #20 was performed on 10/05/2025. Severity: 2 Scope: 1			
Y 0920 SS= D	NAC 449.2748	Y 0920	NAC449.2748 - Medication Storage for Self Administration & Memory Care	02/28/2026

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	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 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, document review, and interview, the facility failed to ensure residents' medications were kept secured in		1) How you will correct the specific finding(s) stated in the SOD? All medications for residents in rooms #139, #166, #155, #164 & #285 were immediately secured in locked storage. Reassessments of all residents under self-administration for self-administration capability will be completed by Wellness Director and/or Designee by 2/28/2026. 2) What measures will be put into place to ensure the deficient practice does not recur? Residents approved for self-administration will be reassessed every six months and upon change in condition. Staff were re-educated on 10/25/25. 3) How the corrective action(s) will be monitored? Weekly audits for 60 days, then quarterly. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Nurses; Wellness Director; Memory Care Director and/or Designee 5) The date the corrective action will be completed? 2/28/2026	

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	the facility for 1 of 7 resident rooms with a self-administering resident (Room #139) and 2 of 23 resident rooms in the memory care unit. Findings include: On 10/08/2025, the following rooms with a self-administering resident contained unsecured medications: - Room 166 in the memory care unit – at 10:03 AM, the following medications were in an unlocked bathroom cabinet: - a one-ounce container of Systane Original Lubricant eye drops - a 0.33-ounce container of Refresh lubricant eye drops - Room 155 – at 10:50 AM, the resident was not in the room, the room was unlocked, and the following medications were unsecured: - a daily pill sorter with miscellaneous pills - Senna 8.6 milligrams, 250 tablets - Tylenol Extra Strength 500 milligrams, 100 caplets - Meloxicam 7.5 milligrams - Sertraline HCL 500 milligrams - Amlodipine 10 milligrams - Gabapentin 100 milligrams - vitamin D3 1000 IU - magnesium glycinate 240 milligrams - Room 164 – at 10:57 AM, the resident was in the room and verbalized the room was not always locked when out and the following medications were unsecured: - a daily pill sorter with miscellaneous pills - Fexofenadine HCL 180 milligrams, six bubble packs with five pills in each - Room 285 – at 11:16 AM, two spouses were in the room. One spouse self-administered medication, and the other spouse had the facility manage medication. The self-administering spouse was asleep and the spouse who had the facility manage medications was awake. The following medications were unsecured: - two nitroglycerine sublingual 0.4 milligrams - Tylenol PM			

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	- Pepto Bismol On 10/08/2025 at 10:03 AM through 11:16 AM, the Wellness Director confirmed the medications were not secured. Severity: 2 Scope: 1			
Y 0905 SS= D	**NAC 449.2746** **Administration of medication: Restriction concerning medication taken as needed by resident; written records.** 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his need for the medication; (b) The determination is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the amount of medication that may be given, and the frequency with which the medication may be given. 2. A caregiver who administers medication toa resident as needed shall record the following information concerning the administration of the medication:	Y 0905	**NAC449.2746 – PRN Medications Specific Symptoms/Frequency** 1) How you will correct the specific finding(s) stated in the SOD? All cited PRN orders were corrected or requested from the prescribing provider to ensure proper indication and frequency. Corrections were completed or requested by the documented dates. **Resident#14**Acetaminophen 325 mg indication was listed as mild pain – order was corrected11/10/25 to one tablet by mouth every 4 hours as needed for headache or backpain. **Resident#17**Hydrocodone-Acetaminophen 7.5-325 mg tablets show indication listed as severe or moderate pain. Correction of the doctor's order was requested via fax on12/23/25 and received back from the physician on 12/24/25. **Resident #25** Lubricant eye drops 0.5% solution did state the frequency of PRN but did not state indication to be given. The corrected order with proper indication was received/dated 11/7/25. 2) What measures will be put into place to ensure the deficient practice does not	01/06/2026

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	(a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse. Inspector Comments: Based on observation, interview, clinical record review and document review, the facility failed to ensure 1) physician orders for medications to be administered on an As Needed (PRN) basis included written instructions indicating the specific symptom for which a medication was to be given and the frequency at which the medication could be given for 1 of 25 sampled residents (Resident #25) and 2) the administration of a PRN medication did not require an assessment to determine if the medication was appropriate to administer for 2 of 25 sampled residents (Resident #14 and #17). Findings include: Resident #25 Resident #25 was admitted to the facility on 02/27/2025, with diagnoses including flaccid hemiplegia affecting left dominant side and hypertension. Resident #25's October 2025 Medication Administration Record (MAR) documented Lubricant eye drops 0.5 percent (%) solution, instill one drop into both eyes PRN for. A Physician's Order dated 10/03/2025,		recur? Wellness Director and/or designee will pull weekly PRN medication report and review for indications for administration and frequency, any discrepancies identified during audits to be addressed. 3) How the corrective action(s) will be monitored? Monthly monitoring via QA of PRN medication audits and spot checks. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Nurses, Wellness Director, Memory Care Director and/or Designee 5) The date the corrective action will be completed? 1/6/2026	

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	documented Lubricant eye drops 0.5 % solution, instill one drop into both eyes PRN for. On 10/08/2025 at 2:59 PM, during a review of Resident #25's medications and in the presence of a Medication Technician (Med Tech), a bottle of Lubricant eye drops 0.5 % solution was observed. The label on the bottle documented instill one drop in both eyes PRN for. The Med Tech acknowledged the label on the bottle of Lubricant eye drops and Resident #25's MAR lacked an indication and frequency for administration of the medication. The Med Tech confirmed PRN medications were required to have a symptom for which the medication was to be administered and the frequency at which staff could administer the medication. Resident #14 Resident #14 was admitted to the facility on 10/04/2023, with a diagnosis of hypertension and dementia. Resident #14's October 2025 MAR documented Acetaminophen 325 milligram tablets, take one tablet by mouth every four hours PRN for mild pain. A Physician's Order dated 07/17/2025, documented Acetaminophen 325 mg tablets, take one tablet by mouth every four hours PRN for mild pain. On 10/08/2025 at 2:48 PM, during a review of Resident#14's medications, the Med Tech acknowledged the indication for administration of Acetaminophen was documented as mild pain. Resident #17 Resident #17 was admitted to the facility on 08/21/2025, with diagnoses including congestive heart failure and rheumatoid arthritis. Resident #17's October 2025 MAR documented Hydrocodone-Acetaminophen			

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	7.5-325 mg tablets, take one tablet by mouth every four hours PRN for severe or moderate pain. A Physician's Order dated 09/16/2025, documented Hydrocodone-Acetaminophen 7.5-325 mg tablets, take one tablet by mouth every four hours PRN for severe or moderate pain. On 10/08/2025 at 2:55 PM, during a review of Resident #17's medications, the Med Tech acknowledged the indication for administration of Hydrocodone-Acetaminophen was documented as severe or moderate pain. The Med Tech verbalized the Med Tech did not know how staff knew when it was appropriate to administer Acetaminophen to Resident #14 and Hydrocodone-Acetaminophen to Resident #17. The Med Tech explained the Med Tech could not assess residents for pain and determine if residents' pain was mild, moderate or severe. The facility policy titled "Medication Assistance," revised 10/2023, documented when a PRN medication was given, staff were to document the reason for and the resident's response to the medication. All PRN medications were required to have clear directions for use and avoid ranges of doses and/or frequency. Severity: 2 Scope: 1			
Y 0885 SS= D	**NAC 449.2742** **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the	Y 0885	**NAC449.2742 – Discontinued Medications Removed & Destroyed** 1) How you will correct the specific finding(s) stated in the SOD? The discontinued Lidocaine patch for Resident #25 was immediately removed from cart and destroyed on 10/16/25. 2) What measures will be put into place to ensure the deficient practice does not recur? Weekly cart audits for 90 days by	02/28/2026

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	medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, interview, clinical record review and document review, the facility failed to ensure a medication which had been discontinued for 1 of 25 sampled residents (Resident #25) was removed from a medication cart and destroyed. Findings include: Resident #25 Resident #25 was admitted to the facility on 02/27/2025, with diagnoses including flaccid hemiplegia affecting left dominant side and hypertension. A Physician's Order dated 09/19/2025, documented discontinue Lidocaine patch. Change to Diclofenac Sodium 1 percent (%), apply topically to right elbow two times per day as needed for right elbow pain. On 10/08/2025 at 2:59 PM, during a review of Resident #25's medications and in the presence of a Medication Technician (Med Tech), a box of Lidocaine 4 percent (%) patches was stored with the resident's active medications. Resident #25's October 2025 Medication Administration Record (MAR) did not include Lidocaine patches. The Med Tech acknowledged Resident #25's October 2025 MAR did not include Lidocaine patches. The Med Tech reviewed the MAR in the facility's electronic medical record system and verbalized the medication had been discontinued on 09/19/2025. The Med Tech verbalized a Med Tech was		Nurses, Wellness Director, Memory Care Director and/or Designee. 3) How the corrective action(s) will be monitored? Monthly review of audits by the Wellness Director, Memory Care Director and/or Designee. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Nurses, Wellness Director, Memory Care Director, and/or Designee 5) The date the corrective action will be completed? 2/28/2026	

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	assigned to audit medication storage carts at least once per week. During the weekly audit, expired and/or discontinued medications were to be removed and destroyed. The facility policy titled “Medication Assistance,” revised 10/2023, documented any medication which had been discontinued was to be disposed of according to state regulations and per pharmacy recommendations. Scope: 2 Severity: 1			
Y 1840 SS= E	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on employee record review and interview, the facility failed to ensure an unlicensed caregiver completed annual infection control and prevention training for	Y 1840	**R063-21 Sec. 4. 1. -Unlicensed Caregiver Annual Infection Control Training** 1) How you will correct the specific finding(s) stated in the SOD? By2/28/2026, employees #1, #6, #9, #12 & #18 will complete state-approved annual infection control training. 2) What measures will be put into place to ensure the deficient practice does not recur? Infection control training has been added to the employee compliance tracking system and will be monitored monthly. 3) How the corrective action(s) will be monitored? Executive Director and/or Designee to monitor infection control training via compliance tracking system weekly for 1 month and monthly thereafter until compliance has been met. Ongoing compliance monitoring by the Business Office Manager. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Business Office Manager and/or Designee 5) The date the corrective action will be completed?	02/28/2026

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	5 of 23 employees (Employee #1, #6, #9, #12 and #18). Findings include: Employee #1 Employee #1 was hired as the Administrator on 09/18/2015. Employee #1's record documented the employee had completed infection control and prevention training on 02/01/2024; however, lacked documented evidence of annual infection control and prevention training in 2025. Employee #6 Employee #6 was hired as a Care Associate on 08/30/2023. Employee #6's record documented the employee had completed infection control and prevention training on 01/24/2024; however, lacked documented evidence of annual infection control and prevention training in 2025. Employee #9 Employee #9 was hired as a Care Associate on 06/03/2024.		2/28/2026	

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	Employee #9's record documented the employee had completed infection control and prevention training on 06/06//2024; however, lacked documented evidence of annual infection control and prevention training in 2025. Employee #12 Employee #12 was hired as a Medication Technician on 09/04/2024. Employee #12's record documented the employee had completed infection control and prevention training on 01/25/2024; however, lacked documented evidence of annual infection control and prevention training in 2025. Employee #18 Employee #18 was hired on 01/12/2015. Employee #18's record documented the employee had completed infection control and prevention training on 02/26/2024; however, lacked documented evidence of annual infection control and prevention training in 2025. 10/08/2025 at 3:32 PM, the Business Office Manager verbalized the employees were to take unlicensed caregiver training annually. The BOM confirmed employees #1, #6, #9, #12 and #18 lacked annual unlicensed caregiver training.			

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	Severity: 2 Scope: 2			
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 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	Y 1825	**NAC449.0109 – Person Responsible for Infection Control** 1) How you will correct the specific finding(s) stated in the SOD? The Wellness Director will complete annual infection control and prevention training. 2) What measures will be put into place to ensure the deficient practice does not recur? Primary and secondary designees will be notified of annual training requirements by 1/31/2025. 3) How the corrective action(s) will be monitored? Executive Director or designee will monitor training due dates via QA monthly for 3months until compliance is met, then ongoing after. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented? Executive Director and/or Designee 5) The date the corrective action will be completed? 2/28/2026	02/28/2026

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	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 employee record review and interview the facility failed to ensure the primary staff member responsible for infection control completed 15 hours of infection control and prevention training annually. Findings include: Employee #2 Employee #2 was hired on 11/26/2013 as the Wellness Director. Employee #2's record documented the employee had completed infection control and prevention training on 05/11/2024; however, lacked documented evidence of annual infection control and prevention training in 2025. On 10/08/2025 at 11:43 AM, the Business Office Manager (BOM) confirmed the Wellness Director was the primary staff member responsible for infection control. The BOM confirmed the Wellness Director had not completed annually infection control training for 2025. Severity: 2 Scope: 3			