STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 08/05/24 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files and three employee files were reviewed. The facility received a grade of C. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0179 SS= D	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview, the facility failed to ensure a screen was on the window in Resident #2 (R2's) room. Findings include: On 08/05/24 at 12:04 PM, the window in R2's room was without a screen to keep insects out. On 08/05/24 in the afternoon, the Caregiver acknowledged the window in R2's room did not have a screen. Severity: 2 Scope: 1	0179	On 08/05/24 The window in R2's room was without a screen to keep insects out. R 2 Screen was replaced Picture has been uploaded. The Group Home Manager will do monthly checks on any repairs or replacements on a monthly basis. Completed 9/5/2024.	09/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation and interview, the facility failed to ensure restraints were not being used for 1 of 5 residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 07/02/24 with a diagnosis of Alzheimer's Disease with Late Onset. On 08/05/24 at 12:06 PM, R3 was sitting up in bed, eating lunch. The left side of R3's bed was pushed up against the wall. The right side of the bed had a quarter rail at the head of the bed and a large easy chair was pushed up against the right side of the bed on the lower half. R3 was enclosed on both sides of the bed. On 08/05/24 at 12:27 PM, the Caregiver reported R3 might get up in the bed but was not able to stand up unassisted. The Caregiver explained the chair was positioned there as a safety precaution to prevent a fall when the Caregiver was not present. Severity: 2 Scope: 1	0557	R3 was observed lying in bed, with half bed rails up on both sides of the bed. On 8/05/24. Hospice was notified by the Group home Manager and explained to hospice about R # 3 that they could not use half bed rails the concern from hospice is possible falls. The facility concern was safety for R#3 and has rearranged the room. Hospice has Lowered bed rails down and lowered the bed and has ordered safety Matts on 9/5/2024 for both sides of bed please. The facility will not use half bed rails, and the group home manager will ensure that this does not occur again the Administrator will check upon every visit to ensure that this does not occur again Completed 9/05/2024.	09/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
0859 SS= D	Medical Care of Resident After Illness - 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. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on record review and interview, the facility failed to ensure a general physical examination was conducted for 1 of 5 residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 07/02/24 with a diagnosis of Alzheimer's Disease with Late Onset. R3's file lacked documented evidence of an initial physical examination conducted prior to admittance to the facility. On 08/05/24 in the afternoon, the Caregiver acknowledged there was no physical examination on file for R3. Severity: 2 Scope: 1	0859	The facility will ensure that 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 will obtain the results of a general physical examination of the resident by a qualified provider of healthcare. The Group home Manager will make sure that all Admission and Annual Physical are completed in a timely manner and will file in the resident file. Administrator will monitor on a monthly basis of any new resident or any annuals that are due. Annual Physicals have been uploaded for R#3and were completed on 7/05/2024.	09/05/2024
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) 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, including, without limitation, whether the medication is to be administered according to a routine	0895	The facility will ensure the Medication Administration Record (MAR) (Resident #4) was corrected immediately after the survey on 8-5-2024. The Group home manager and administrator will do Monthly audit to ensure that all medications match Dr. Order Medications to MAR'S and Labeling. All staff was reminded of Eight Right of Medication Administration All DOC'S have been uploaded. Completed 9/5/2024.	09/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
	schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 5 residents (Resident #4). Findings include: Resident #4 (R4) R4 was admitted on 04/25/24 with diagnoses including urinary tract infection (UTI) and difficulty in walking. A physician order dated 04/30/24 documented Metoprolol 25 mg, one-half tablet by mouth twice a day. R4's August 2024 MAR documented Metoprolol Tar 25 milligram (mg) tablet, take one tablet by mouth twice a day. The Medication bubble package was labeled Metoprolol Tar 25 mg tablet, take 1/2 tablet by mouth twice a day. On 08/05/24 in the afternoon, the Caregiver verbalized R4 received 1/2 tablet of Metoprolol twice a day. The Caregiver acknowledged the MAR did not document the 1/2 tablet which was what the physician order and bubble pack documented. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
0936 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to ensure 3 of 5 residents met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441a (Residents #1, #3, and #5). Findings include: Resident #1 (R1) R1 was admitted on 07/31/24 with a diagnosis of Dementia with Lewy Bodies. R1 completed a One-Step TB test on 06/14/24. R1's file lacked documented evidence of a completed Two-Step TB test. Resident #3 (R3) R3 was admitted on 07/02/24 with a diagnosis of Alzheimer's Disease with Late Onset. R3's file documented a Two-Step TB test on 09/10/22 with a negative result. The two step TB test was more than 12 months from R3 being admitted and therefore was not acceptable according to (NAC) 441a. R3's file also lacked documented evidence of an annual TB test for 2023. Resident #5 (R5) R5 was admitted to the facility on 05/22/23 with diagnoses including hypertension and eczema. R5 completed a Two-Step TB test on 05/23/23. R5's file lacked documented evidence of an annual TB test in 2024. On 08/05/24 in the afternoon, the Caregiver acknowledged R1, R3, and R5 files lacked documented evidence of current TB testing to meet the requirement. Severity: 2 Scope: 3	0936	The facility will ensure that residents meet the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441a. All residents will have an initial 2 step TB Test upon admission and Annual 1 step TB Test. Group home manager to ensure proper paperwork is in place for any new admission and that annual TB Test is conducted. The Administrator will check on a monthly basis. TB Test have been uploaded for R # 3 R # 5. R # 1 Expired on 8/10/2024. Completed on 9/5/2024.	09/05/2024
0938 SS= F	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident;	0938	The facility will ensure that an evaluation of the resident ' s ability to perform the activities of daily living and a brief	09/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
	confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she 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 or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure Activities of Daily Living (ADL) Assessments were conducted for 3 of 5 residents (Residents #3, #4, and #5). Findings include: Resident #3 (R3) R3 was admitted on 07/02/24 with a diagnosis of Alzheimer's Disease with Late Onset. R3's file lacked documented evidence of an ADL assessment upon admit to the facility. Resident #4 (R4) R4 was admitted on 04/25/24 with diagnoses including urinary tract infection (UTI) and difficulty in walking. R4's file lacked documented evidence of an ADL assessment upon admit to the facility. Resident #5 (R5) R5 was admitted on 05/23/23 with diagnoses including hypertension and eczema. R5's initial ADL assessment was conducted on 05/19/23. R5's file lacked documented evidence of an annual ADL assessment for 2024. On 08/05/24 in the afternoon, the Caregiver acknowledged initial ADL assessments had not been conducted for R3 and R4, and an annual ADL assessment had not been conducted for R5. Severity: 2 Scope: 3		description of any assistance he or she needs to perform those activities. The Group home manager will ensure that all initial and annual assessments are in place and completed. The administrator will check on a monthly basis. R #3 R # 4 R # 5. ADL Assessment have been uploaded and Completed 9/5/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure door alarms were set. Findings include: On 08/05/24 at 11:25 AM, the door leading from a Caregiver's room to the front yard had three locks and was equipped with an alarm that did not sound when the door was opened. The Caregiver's room was accessible to residents. On 08/05/24 in the morning, the Caregiver acknowledged the alarm did not sound, and verbalized the staff felt the door was secure from elopements because it contained three locks. Severity: 2 Scope: 3	0991	The facility will ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. The Door alarm batteries were replaced on 8/5/2024 and is Operational. The group home manager and administrator will check upon every visit. Corrected 8/5/2024.	08/05/2024
1700 SS= E	Annual Assessment of History of Each Resident - 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 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	1700	The facility Will ensure that an initial placement assessment will be obtained for any resident admitted to the facility. The day of survey this was not available in the resident file but was done and misfiled into the residents financial file instead. R#2, R# 4 have been uploaded and put into the resident file which has been corrected. The Group Home Managerwill do the initial assessment according to the bureau recommendations and regulation. The Administrator will double check on a monthly basis to ensure that all initial assessments are done and completed as well as being filed in the resident file. Completed 9/05/2024	09/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
	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. 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 facility failed to ensure an initial placement assessment was obtained for 2 of 5 residents (Residents #2 and #4). Findings include: Resident #2 (R2) R2 was admitted on 02/17/24 with diagnoses including chronic obstructive pulmonary disease (COPD) and heart failure. R2's file lacked documented evidence of a current placement assessment by R2's physician. Resident #4 (R4) R4 was admitted on 04/25/24 with diagnoses including urinary tract infection (UTI) and difficulty in walking. R4's file lacked documented evidence of a current placement assessment by R4's physician. On 08/05/24 in the afternoon, the Caregiver acknowledged the lack of a physician placement document in R2 and R4's files.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11218	A. BUILDING _____ B. WING _____	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE VALLEY ELDER CARE	465 RIDGEWAY RD, HENDERSON, NEVADA ,89015

(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
	Severity: 2 Scope: 2			
1840 SS= D	UNL Caregiver Training - R063-21 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 record review and interview, the facility failed to ensure 1 of 3 employees obtained the required infection control training (Employee #2). Findings include: Employee #2 (E2) E2 was hired on 04/06/24 as a Caregiver. E2's file lacked documented evidence of training concerning the control and prevention of infections from the approved nationally recognized organizations. On 08/05/24 in the afternoon, E2 acknowledged the required infection control training was not complete. Severity: 2 Scope: 1	1840	The facility Will ensure and obtained the required infection control training is done within 30 days of hire and to be done annually the group home manager will ensure training is completed and Administrator will monitor on a monthly basis to ensure compliance. (Employee #2) Training is uploaded and completed 9/5/2024.	09/05/2024