STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155	A. BUILDING _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE HOME	7560 SILVER LEAF WAY, LAS VEGAS, NEVADA ,89147

(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 an annual survey initiated at your facility on 09/03/25. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, Category II residents. The census at the time of the survey was eight. Eight resident files and five employee files were reviewed. The facility received a grade of D.			
Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or	Y 0172	Y 0172 NAC 449.209 1. The Facility is well maintained in and out. The exercise bike is greatly placed in the backyard for people to use and not inside. Every house in Las Vegas has a weekly services of picking up the garbage by Republic Services in all neighborhood. and every garbage can has an attached lid or cover. 2. Caregivers are automatically put, retrieve and clean the can after every pick-up. 3. There is no infestation by rodents or insects because of Pest Control and gardeners cleaning the yard regularly every month. and Facility Manager on duties and the Administrator are monitoring to ensure deficient practice will not recur. 4. The Facility Administrator ensures the Plan of Correction is implemented. 5. September 03, 2025 6. See Attachment : Appendix " A"	10/24/2025

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	medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the back yard of the facility was well-maintained. Findings include: On 09/03/25 at 10:45 AM, the following items were observed to be stored outside in the back yard: -a rolling commode			

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	-a walker -two wheelchairs -an exercise bike. On 09/03/25 at 4:25 PM, Employee #1 acknowledged the items in the back yard and noted they should not be stored there. Severity:2 Scope: 3 This is a repeat deficiency from the 08/16/23 and 08/07/24 annual surveys. Severity: 2 Scope: 3			
Y 0515 SS= F	NAC 449.259 **Supervision of residents.** 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive	Y 0515	Y 0515 NAC 449.259 1. The Staff of Residential Facility shall ensure that the each resident shall be provided with good health care. The facility should develop each resident a person-centered Service Plan. 2. It should provide concerning Activities of daily living, medication management cognitive safety, assistive devices on special needs develop and involvement of ancillary services and participate in personal and private pastoral counselling. And Laundry services 3. The Facility Administrator and the House Manager will work hand in hand to ensure safety, develop social and recreational needs. 4. The Administrator will ensure the Plan of Correction is implemented and is the responsible person.	10/24/2025

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	safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to have person-centered service plans for 7 of 8 residents (Residents #1, #2, #3, #4, #5, #6, and #7). Findings include:		5. October 01, 2025 6. See Attachments Appendix " B "	

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	Resident#1 (R1) R1was admitted on 01/31/24 with diagnoses including traumatic brain injury and essential hypertension. R1's file contained a Person-Centered Service Plan form which had been filled out but not dated and not signed by R1's Power of Attorney (POA) or by the facility Administrator. Resident#2 (R2) R2 was admitted on 12/23/23 with diagnoses including other pulmonary embolism, chronic obstructive pulmonary disease (COPD), and hypertension. R2'sfile contained a Person-Centered Service Plan form which had been filled out, but not dated and not signed by R2's Power of Attorney or by the facility Administrator. Resident#3 (R3) R3was admitted on 03/02/19 with diagnoses including dementia, hypertension, and depression.			

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	R3'sfile lacked documented evidence of a Person-Centered Service Plan. Resident#4 (R4) R4 was admitted on 10/07/16 with a diagnosis of seizure disorder. R4's file lacked documented evidence of a Person-Centered Service Plan. Resident#5 (R5) R5 was admitted on 12/21/20 with diagnoses including hypertension, Type 2 Diabetes Mellitus, and pulmonary nodules. R5'sfile lacked documented evidence of a Person-Centered Service Plan. Resident#6 (R6) R6 was admitted on 08/29/07 with diagnoses including depression and elevated triglycerides. R6'sfile contained a Person-Centered Service Plan which had been filled out,			

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	but with no date and not signed by R6's POA or by the Administrator of the facility. Resident#7 (R7) R7 was admitted on 04/09/14 with diagnoses including acute kidney injury and lower obstructive neuropathy. R7's file contained a Person-Centered Service Plan which had been filled out, but with no date and not signed by R7's POA or by the Administrator. On 09/03/25 in the afternoon, the Administrator acknowledged the facility had not developed Person-Centered Service Plans for R3, R4 or R5, and that the Person-Centered Service Plans for R1, R2, R6 and R7 were undated and not signed by the respective POAs nor by the Administrator. Severity:2 Scope: 3 This is a repeat deficiency from the 08/07/24 annual survey.			
Y 0740 SS= D	NAC 449.272	Y 0740	Y 0740 NAC 449.272	10/24/2025

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	Residents requiring use of indwelling catheter. 1. A person who requires the use of an indwelling catheter must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The resident is physically and mentally capable of caring for all aspects of the condition, with or without the assistance of a caregiver; (b) Irrigation of the catheter is performed in accordance with the physician's orders by a medical professional who has been trained to provide that care; and (c) The catheter is inserted and removed only in accordance with the orders of a physician by a medical professional who has been trained to insert and remove a catheter. 2. The caregivers employed by a residential facility with a resident who requires the use of an indwelling catheter shall ensure that: (a) The bag and tubing of the catheter are changed by: (1) The resident, with or without the assistance of a caregiver; or (2) A medical professional who has been trained to provide that care; (b) Waste from the use of the catheter is disposed of properly; (c) Privacy is afforded to the resident while care is being provided; and (d)The bag of the catheter is emptied by		1. Resident #7 has been in the Facility since 04/09/2014 and does not have a foley catheter then. after some time because of acute kidney disease he was provided by his Doctor to have a foley catheter and a Home Health nurse has assisted him with this care. He has been trained to empty his catheter bag and his Home Health Nurse will change his foley catheter or the Doctor will assist in the replacement or what is needed to prevent urinary tract infections. 2. A Catheter waiver has been applied and the Home Health provider has supplied the necessary Plan of Care to support the application. 3. The Facility Administrator together with the Facility Manager will monitor the deficient practice is taken cared with the visiting Home Health Nurse to see the catheter care and provided safety for resident #7. 4. The Administrator will be responsible to ensure the plan of correction is implemented. 5. October 23, 2025 6. See Appendix "C"	

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	a caregiver who has received instruction in the handling of such waste and the signs and symptoms of urinary tract infections and dehydration. Inspector Comments: Based on observation, interview, and record review, the facility failed to apply for a medical exemption to retain a resident with a Foley catheter (Resident #7). Findings include: Resident#7 (R7) R7 was admitted to the facility on 04/09/14 with diagnoses including acute kidney injury and lower obstructive neuropathy. On 09/03/25 in the afternoon, it was revealed by the Administrator that R7 had a Foley catheter. The Administrator described the Foley catheter as strapped to R7's leg, hidden by R7's pants. On 09/03/25 at 4:13 PM, R7 explained R7emptied the catheter bag but did not clean it. Per R7, a nurse replaced R7's catheter monthly. In an interview in the afternoon, the Administrator indicated the facility had not submitted an application to the Bureau for a medical waiver to retain R7 as a resident. On 09/03/25 in the afternoon, the Administrator acknowledged the facility should have submitted for a medical exemption to retain R7 as a resident.			

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	Severity:2 Scope: 1			
Y 0870 SS= F	NAC 449.2742 **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility.	Y 0870	Tag Y 0870 NAC 449.2742 1. Administration of Medication is a very important matter in life sustaining vital importance. Residents signed User agreements in coincidental matters with their Primary Care Physicians that they will allow Facility Med Tech staff to provide them their routine daily medicines. Medication Reviews are given by their trusted Pharmacies and needs to be reviewed and ensure the 6-month medication review by their Doctors and/or Pharmacists and the Administrator should signed and reviewed the medications as well. 2. Medication Review are submitted by the residents Pharmacy and acknowledged and signed by Facility Administrators or Doctors upon arrival or faxed to the Facility of the Residents. 3. Every 6 months reviews are sent by their Pharmacy and Administrator will sign and review these medications and monitored to ensure deficient practice will not recur. 4. The Administrator and Facility Manager work hand to hand to make sure medications are secured, safe and available to each resident with the responsibility of the Facility Administrator 5. October 23, 2025 6 See attachments : Appendix " D"	10/24/2025

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	(b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure 6-month medication reviews were conducted for residents, and/or the Administrator had reviewed and initialed medication reviews, for 8 of 8 residents (Residents #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident#1 (R1) R1was admitted on 01/31/24 with diagnoses including diffuse traumatic brain injury and essential hypertension. R1'sfile contained medication reviews dated 01/31/25 and 07/15/25. Neither medication review contained the initials of the Administrator to indicate the			

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	Administrator had reviewed the medication reviews within 72 hours. Resident#2 (R2) R2 was admitted on 12/23/23 with diagnoses including other pulmonary embolism, chronic obstructive pulmonary disease, and hypertension. R2'sfile contained a medication review dated 07/19/24. R2's file lacked documented evidence of medication reviews since 07/19/24. Resident#3 (R3) R3was admitted on 03/02/19 with diagnoses including dementia, hypertension, and depression. R3's file contained medication reviews dated 01/31/25 and 07/15/25, with no evidence of Administrator initials/review. Resident#4 (R4) R4 was admitted on 10/07/16 with a diagnosis of seizure disorder.			

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	R4'sfile contained medication reviews dated 01/31/25 and 07/15/25, with no evidence of Administrator initials/review. Resident#5 (R5) R5 was admitted on 12/21/20 with diagnoses including hypertension, Diabetes Mellitus Type 2, and pulmonary nodules. R5's file contained one medication review dated 07/15/25, without evidence of Administrator initials/review. R5's file lacked documented evidence of a medication review six months prior to 07/15/25. Resident#6 (R6) R6 was admitted on 08/29/07 with diagnoses including depression and elevated triglycerides. R6'sfile contained medication reviews dated 01/31/25 and 07/15/25, with no evidence of Administrator initials/review. Resident#7 (R7)			

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	R7 was admitted on 04/09/14 with diagnoses including acute kidney injury and lower obstructive neuropathy. R7'sfile contained a medication review dated 07/15/25, without evidence of Administrator initial/review. R7's file lacked documented evidence of a medication review conducted six months prior to 07/15/25. Resident#8 (R8) R8 was admitted on 09/01/23 with diagnoses including hypertension, Diabetes Type 2, and COPD. R8's last medication review was conducted 01/30/24, per documentation in R8's file. R8'sfile lacked documented evidence of current every-six-month-medication reviews. On 09/03/25 in the afternoon, the Administrator acknowledged R1, R2, R3, R4, R5, R6, R7 and R8 were missing varying 6-month medication reviews, and affirmed medication reviews should have been reviewed and initialed by the Administrator within 72 hours of review by the pharmacist, physician, or registered nurse. Severity:2 Scope: 3			

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Y 0885 SS= E	**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 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, record review, and interview, the facility failed to ensure expired medications were destroyed for 2 of 8 residents (Residents #3 and #4). Findings include: Resident#3 (R3) R3 was admitted on 03/02/19 with	Y 0885	Tag Y 0885 NAC 449.2742 1. Resident #3 has two tubes of A&D ointment the expired one left in the bin is untouched (brand new) the usable one was placed in the drawer of the resident and un-expired and continues to be used. The expired one was destroyed at Walmart Pharmacy. Same thing to Resident #4 medications were destructed at Walmart Pharmacy on 10/23/2025 and were all replaced. 2. There must a review of all medications for the residents to be checked periodically for better and safe environment and safekeeping 3. Periodic checking and safekeeping of medicines will be monitored by the Facility Administrator, Manager and Med Tech to monitor and ensure the deficiency practice will not recur. 4. The Facility Administrator is responsible for ensuring the Plans of Correction is implemented. 5. October 23, 2025 6 See : Appendix "F"	10/24/2025

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	155	A. BUILDING _____ B. WING _____	09/03/2025

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	diagnoses including dementia, hypertension, and depression. R3's September 2025 Medication Administration Record (MAR) documented Vitamin A&D ointment, apply to affected skin once a day. On 09/03/25 at 5:00 PM during medication review, it was discovered the Vitamin A&D ointment in R3's medication bin had expired on 09/16/24. A review of R3's September MAR revealed Vitamin A&D ointment had been administered to R3 09/01/25 through 09/03/25. Resident#4 (R4) R4 was admitted on 10/07/16 with a diagnosis of seizure disorder. R4's August and September 2025 MARs documented Tamsulosin 0.4 milligrams (mg), take one capsule by mouth at bedtime. On 09/03/25 at 5:34 PM during medication review, it was discovered the Tamsulosin in R4's medication bin had expired on 02/24/25. A review of R4's August and September MARs revealed Tamsulosin had been administered to R4 from 08/01/25 through 09/02/25.			

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	R4's September 2025 MAR documented Levothyroxine 112 micrograms (mcg), take one tablet by mouth once a day. On 09/03/25 at 5:34 PM during medication review, it was discovered the Levothyroxine in R4's medication bin had expired on 08/31/25. A review of R4's September MAR revealed Levothyroxine had been administered to R4 from 09/01/25 through 09/03/25. On 09/03/25 in the afternoon, the Caregiver acknowledged R3's A&D ointment and R4's Tamsulosin and Levothyroxine had expired, and the medications should have been destroyed and replaced. Severity:2 Scope: 2			
Y 0920 SS= F	NAC 449.2748 Medication Storage. 1. Medication including, without limitation, any over-the-counter medication stored at a residential facility must be stored in a locked area	Y 0920	Tag Y 0920 NAC 449.2748 MEDICATION STORAGE 1. Resident #2 is taking Morphine 20 mg as needed for pain/shortness of breath A locked bag was stored in the refrigerator and the medicine was not properly placed for the first time. the locked bag has been shown to the surveyor that there is a locked bag for medications to be secured. 2. The morphine medication was stored	10/24/2025

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	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 and interview, the facility failed to ensure medication was properly stored for 1 of 8 residents (Resident #2). Findings include:		back tot he locked bag where it is placed for safekeeping. 3. Facility Manager and MedTech must ensure restricted medications must be locked and back and secured in locked bag in refrigerator 4. Facility Administrator will monitor and responsible for ensuring the plan of correction is implemented. 5. October 03, 2025 6. See Appendix " G "	

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	Resident#2 (R2) R2 was admitted on 12/23/23 with diagnoses including other pulmonary embolism, chronic obstructive pulmonary disease (COPD), and hypertension. R2's September 2025 MAR documented Morphine 20 milligrams (mg)- 15 milliliters (ml), take 0.5 ml by mouth every four hours as needed for pain/shortness of breath. On 09/03/25 at 5:55 PM, when the Caregiver removed Resident #2's morphine from the refrigerator at the request of the surveyor as part of the medication review process, the morphine was observed to be stored unsecured in the refrigerator door. On 09/03/25 in the afternoon, the Caregiver agreed the morphine should have been locked up, and showed the surveyor the lockbox the facility had for controlled medications. Severity:2 Scope: 3			
Y 1840 SS= E	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who	Y 1840	Tag Y 1840 R063-21 Sec 4 1. Employee #1 who has been hired and	10/24/2025

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	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 2 of 5 care givers had completed the required annual Infection Control training (Employees #1 and #3). Findings include: Employee#1 (E1) E1was hired in 1999 as a Caregiver. E1's employee file contained certificates for infection control training, which expired in August 2025. E1's file lacked documented evidence of annual approved Infection Control training.		started since 1999 and Employee #3 who took care of many residents started in 2016 has many experiences with Senior Care. Their files have contained many certificates and recently had Infection Control Training. 2. Employee #1 who has taken the program for Infection Prevention and Control Training for Unlicensed Caregivers provided by the Nevada Division of Public and Behavioral Health. Same thing goes to Employee #3. 3. An annual completion evidence-based training provided by Nationally recognized organization concerning the control of infectious diseases and should be monitored by the Administrator to ensure the deficient practice will not recur 4. The Administrator is the person responsible for ensuring the Plan of Correction is implemented. 5. October 24, 2025 6. See Appendix " D "	

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	Employee#3 (E3) E3 was hired on 02/15/16 as a Caregiver. E3's file lacked documented evidence of approved Infection Control training. On09/03/25 in the afternoon, the Administrator acknowledged E1 and E3 did not complete infection control training annually. Severity:2 Scope: 2			
Y 1825 SS= E	**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	Y 1825	Tag Y 1825 **NAC 449.0109 Designation and Training of Person responsible for Infection Control** 1. Employee #2 has taken the course of Infection Control and Employee #1 as well. 2. Employees #2 and #4 will retake to update the required 15 hours of Infection Control as this is a program to prevent and control infections within the facility for the dependent residents 3. Administrator will monitor and make sure the deficient practice will not recur 4. The person responsible is the Facility Administrator, ensures the Plan of Corrections is implemented 5. October 24, 2025	10/24/2025

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	Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary Infection Control designees had completed 15 hours of approved infection control training (Employees #2 and #4). Findings include: Employee# 2 (E2) E2 was hired as the Administrator in 1999. E2 was designated as the facility's primary Infection Control responsible staff. E2’s file contained certificates from approved infection control training which had expired in August 2025. E2’s file lacked			

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	documented evidence of 15 hours of current infection control training. Employee#4 (E4) E4 was hired on 09/30/12 as a Caregiver. On 09/03/25 in the afternoon, the Administrator verbalized E4 was the secondary Infection Control person. E4's file lacked documented evidence of 15 hours of approved Infection Control training. On 09/023/25 in the afternoon, the Administrator acknowledged the designated primary and secondary Infection Control responsible persons had not completed the current required infection control training. Severity: 2 Scope: 2 This is a repeat deficiency from the 08/07/24 annual survey.			