STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

(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 a State Licensure annual grading survey conducted at your facility on 03/15/23. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 72 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 32. Ten resident files were reviewed, and ten employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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 investigation, 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		
0065 SS= F	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156	0065	Employee #2 has completed 18 hours of annual caregiver training between 3/22/22-3/21/23. Employee #3 has completed 13 hours of annual caregiver training between 6/27/22-3/15/23.Employee #10 has completed 11 hours of annual caregiver training between 2/9/22-2/8/23.	04/14/2023

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	to 449.27706, inclusive, and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 3 sampled employees working at the facility one year or greater completed at least eight hours of annual Caregiver training (Employee #2, #3, and #10). Findings include: On 03/15/23, the Business Office Director was provided the Personnel Check List to complete for 10 sampled employees. On 03/15/23, the Business Office Director provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Wellness Coordinator with a start date of 03/22/21. Employee #2's personnel file contained documented evidence of 5.5 hours of annual training for the care of elderly/disabled. Employee #3 Employee #3 was hired by the facility as Wellness Director with a start date of 06/27/18. Employee #3's personnel file contained documented evidence of 5.25 hours of annual training for the care of elderly/disabled. Employee #10 Employee #10 was hired by the facility as Medication Technician/Caregiver with a start date of 02/09/21. Employee #10's personnel file contained documented evidence of 5.25 hours of annual training for the care of elderly/disabled. On 03/15/23 at 2:23 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/15/23, confirming the Business Office Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3		Employees are scheduled continuing education courses in addition to monthly staff meetings and any training provided by outside providers to meet and/or exceed the eight hours of annual caregiver training. The Business Office Director will review and update training education monthly following the Quality Assurance Review Schedule –Business Office.	

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0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 1 of 10 sampled employees met the requirements concerning pre-employment physical examination. (Employee #5) Findings include: On 03/15/23, the Business Office Director was provided the Personnel Check List to complete for 10 sampled employees. On 03/15/23, the Business Office Director provided the completed form with the following information: Employee #5 Employee #5 was hired by the facility as Medication Technician/Caregiver with a start date of 12/14/22. Employee #5's personnel file contained an employment physical dated 01/09/23. The physical was conducted 26 days after the start of employment. On 03/15/23 at 2:23 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/15/23, confirming the Business Office Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0102	Employee #5 had the physical and TB Screening completed on 01/09/23, this was the first appointment with the clinic. The facility hassince started using a different clinic for employee physicals and TB testing. The Business Office Director will coordinate appointments for physicals and TB tests upon hire. The Business Office Director will update the Employee Checklist with each new hire and review for compliance monthly following theQuality Assurance Review Schedule – Business Office.	04/14/2023

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0178 SS= D	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 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 Administrator failed to ensure basic upkeep of the facility was maintained. Findings include: On 03/15/23, a pipe in the laundry room was leaking and excessive lint was behind the dryer. On 03/15/23 at 11:06 AM, the Director of Environmental Services and the Maintenance Director confirmed the leak and excessive lint. Severity: 2 Scope: 1	0178	On 3/15/23 the leak was repaired and the lint behind the dryer was cleaned. The staff will receive additional training in completing work orders for the maintenance department when an item needing repair is identified. There is now a schedule for cleaning the lint filters as well as checking/cleaning behind the washer/dryer as needed. The Maintenance Director will audit quarterly and as needed following the Quality Assurance Quarterly Building Inspection.	03/15/2023
0255 SS= D	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 3/16/23, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. The food service room, located at the front of the kitchen, had cabinets and countertops that were excessively worn and damage. b. The dishwashing area was in in poor condition at the time of inspection. A strong foul odor was present. The floor tiles, grout, and wall junctures were damaged which has allowed waste water from the dishmachine to penetrate underneath the tiles and wall junctures. c. The floors underneath equipment throughout the kitchen, cook's line, food preparation, service room, and dry storage were dirty. Severity: 2 Scope: 1	0255	Food service cabinets and countertops are scheduled to be replaced on 4/21/23. The floor in the dish area is scheduled to be repaired by5/31/23 based on the contractor's schedule. The floor in the areas not requiring repair have been cleaned. The dish area will be replaced the week of June 5. No work order but an invoice for completion will be submitted once it is completed. The Dining Services Director will audit cleanliness weekly per the Quality Assurance Review Schedule. The Maintenance Director and Executive Director will audit quarterly per the Quality Assurance Quarterly Building Inspection.	04/21/2023

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0450 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on employee record review and interview, the facility failed to ensure 1 of 10 sampled employees received training to perform cardiopulmonary resuscitation (CPR) and first aid (Employee #6) within 30 days of employment. Findings include: Employee #6 Employee #6 was hired as Medication Technician/Caregiver with a start date of 07/08/22. Employee #6's personnel record contained a CPR and first aid certificate dated 11/13/22, four months and five days after the start of employment. On 03/15/23 at 2:23 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/15/23, confirming the Business Office Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0450	Employee #6 had an active CPR certification prior to hire(see attached). Employee #6 renewed certification on 11/13/22 after an internalaudit identified expiration of current certification. The Business Office Director will obtain and documentcurrent CPR certification upon hire or schedule course to be completed within30 days of hire. Training records will be reviewed monthly by the BusinessOffice Director following the Quality Assurance Review Schedule – BusinessOffice.	03/15/2023
0620 SS= F	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on record review and interview, the facility failed to ensure residents receiving skilled nursing services was not allowed to admit or remain	0620	The facility currently has thirteen residents that are receiving outside services from home health or hospice agencies that do not require 24-hour skilled nursing or medical supervision. These residents benefit from support services in addition to the services provided by the memory care facility. A waiver for resident #1, #7, #9, 11, #12, #13, #14, #15,#16, #18, #19, #20 will be submitted for review on or before 4/15/23. Resident#17 was discharged from outside	04/14/2023

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	in the facility for 13 of 13 (Resident #1, #7, #9, #11, #12, #13, #14, #15, #16, #17, #18, #19, and #20). Findings include: Resident #1 Resident #1 was admitted to the facility on 12/07/20, with a diagnosis including Alzheimer's disease with late onset, major depressive disorder, and anxiety disorder, unspecified. Resident #7 Resident #7 was admitted to the facility on 11/01/21, with diagnosis of Alzheimer's disease. Resident #9 Resident #9 was admitted to the facility on 09/21/17, with diagnoses including dementia and vascular disease. Resident #11 Resident #11 was admitted to the facility on 03/11/20, with a diagnosis of diffuse traumatic brain injury with loss consciousness of unspecified duration. Resident #12 Resident #12 was admitted to the facility on 12/22/22, with unknown diagnoses. Resident #13 Resident #13 was admitted to the facility on 11/22/21, with unknown diagnoses. Resident #14 Resident #14 was admitted to the facility on 08/05/19, with a diagnosis of unspecified dementia. Resident #15 Resident #15 was admitted to the facility on 2/10/20, with a diagnosis of Alzheimer's disease with late onset. Resident #16 Resident #16 was admitted to the facility on 03/19/19, with a diagnosis of dementia, unspecified. Resident #17 Resident #17 was admitted to the facility on 09/29/22, with unknown diagnoses. Resident #18 Resident #18 was admitted to the facility on 04/11/22, with a diagnosis of dementia, unspecified. Resident #19 Resident #19 was admitted to the facility on 06/051/19, with a diagnosis of frontotemporal dementia. Resident #20 Resident #20 was admitted to the facility on 11/27/17, with a diagnosis of Alzheimer's disease. On 03/15/23 at 9:44 AM, the Wellness Director confirmed the facility had thirteen residents receiving skilled nursing care through home health and hospice agencies. The Wellness Director explained the Wellness Director was not aware of the requirement to submit waivers to the State Agency for residents receiving skilled nursing care. The Wellness Director confirmed the facility had not submitted waivers to the State Agency to admit or retain residents receiving skilled nursing care. Severity: 2 Scope: 3		services on 3/14/2023. Resident #9 waiver has been accepted. Approvals for resident #1,#7,#9, #11, #12, #13, #14, #15, #16, #18, #19 & #20 have been received. Please see attached. Resident # 17 was discharged from care on 3/14/2023 please see attached The Executive Director will submit waivers as required for a change in service.	

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0923 SS= A	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 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 clinical record review, the facility failed to ensure an over-the-counter medication had a physician name on the label for 1 of 10 sampled residents (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 11/20/21, with diagnoses including impaired cognition, anxiety, and seizure disorder. Resident #8's March 2023 Medication Administration Record (MAR) documented Captain Morgan 375 milliliters (ml). One ounce by mouth as needed one time per day. The bottle lacked documented evidence of the physician's name and the resident's name on the bottle. A physician order dated 10/10/22, for Resident #8 documented Captain Morgan 375 milliliters (ml). One ounce by mouth as needed one time per day. On 03/15/23 at 12:14 PM, the Medication Technician confirmed the Captain Morgan bottle lacked the physician's name and the resident's name on the bottle. Severity: 1 Scope: 1	0923	The bottle of Captain Morgan was labeled with residentand physician name for resident #8. All medications and treatments have been audited withappropriate labels in place. The med cart will receive spot audits monthly by theWellness Director and quarterly by the nurse consultant from the contractedpharmacy provider.	03/15/2023
0938 SS= E	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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any	0938	Resident #3 had an assessment/service plan completed on2/24/22, the assessment/service plan was reviewed and updated on 3/16/23. Resident#7 had an assessment/service plan completed on 11/28/21, the assessment/service plan was reviewed and updated on 1/18/23 when it was identified that an annual assessment had not been updated. Resident #8 received an updated assessment/service plan on 3/17/23. Resident #9 had an assessment/service plan completed on 11/23/21, the assessment/service plan was reviewed and updated on1/23/23 when it was identified that an annual assessment has not been updated.	03/17/2023

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	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 clinical record review and interview, the facility failed to ensure an Activities of Daily Living (ADLs) assessment was completed annually for 4 of 10 residents (Resident #8, #3, #7, and #9). Findings include: Resident #8 Resident #8 was admitted to the facility on 11/20/21, with diagnoses including impaired cognition, anxiety, and seizure disorder. Resident #8's clinical record documented an initial ADL assessment was completed on 11/28/21. The clinical record lacked documented evidence of an ADL assessment in 2022. On 03/15/23 at 12:00 PM, the Wellness Director confirmed an annual ADL assessment was not completed for Resident #8 in 2022. Resident #3 Resident #3 was admitted to the facility on 02/28/22, with diagnosis including severe dementia and disturbance anxiety. Resident #3's clinical record lacked an annual ADL Assessment. On 03/15/23 at 12:06 PM, the Wellness Director verbalized an annual ADL assessment had not been completed for Resident #3. Resident #7 Resident #7 was admitted to the facility on 11/01/21, with diagnosis including Alzheimer's disease and hypertension. Resident #7's clinical record lacked an annual ADL Assessment. On 03/15/23 at 12:06 PM, the Wellness Director verbalized an annual ADL assessment had not been completed for Resident #7. Resident #9 Resident #9 was admitted to the facility on 09/21/17, with diagnosis including dementia and vascular disease. Resident #9's clinical record lacked an annual ADL Assessment. On 03/15/23 at 12:06 PM, the Wellness Director verbalized an annual ADL assessment had not been completed for Resident #9. Severity: 2 Scope: 2		An audit was completed to ensure that all service plans are current. Current service plans are filed in a separate binder for easier staff access/review. Prior service plans will filed in the chart following the Resident Medical Chart Checklist. Service plans are attached The Wellness Director will complete assessment/service plans per the Service Plan policy and Procedure following the Quality Assurance Review Schedule – Health Services.	

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0999 SS= E	Alzheimer 's Care Standards for Safety - NAC 449.2756 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 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents living in the memory care unit. Findings include: On 03/15/23, during a tour of the facility, the following toxic substances were identified as unsecured: Room 51 - an 11-ounce container of Premier Problem strawberries and cream Room 44 - a 21-ounce container of Jergens ultra healing lotion and two six-ounce tubes of Colgate toothpaste Room 37 - a six-ounce container of Remedy Essentials barrier skin protection and a travel-size tube of Colgate toothpaste Room 26 - a 3.75-ounce bar of Dove soap On 02/05/19, between 8:53 AM and 9:41 AM, the Wellness Director confirmed the above items were unsecured and verbalized the items should have been removed from the residents' rooms. Severity: 2 Scope: 2	0999	Rm #51, #44, #26 had the items listed removed from theapartments. An audit of all resident apartments will be completed toidentify and remove any toxic substances from the apartment. If the resident isin a private suite and has been assessed to safely store the grooming supplies,the service plan will be updated to reflect the ability to safely store and usethe supply.	03/15/2023
1001 SS= E	Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those residents. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 6 sampled employees working at the facility less than one year received four hours of initial training to care for elderly and disabled residents within 60 days of hire (Employee #5, #6, #7, and #8). Findings include: On 03/15/23, the Business Office Director was provided the Personnel Check List to complete for 10 sampled	1001	Employee #5, DOH 12/14/22, completed General Orientation,16 hours of Caregiver Training, and 6.5 hours of additional education with the online learning platform within the first 30 days of employment. Employee #6, DOH 07/08/22, completed General Orientation and 24 hours of Med-Tech Training within the first thirty days of employment. Employee #7, DOH 10/28/22, completed General Orientation,16 hours of Caregiver Training, and 6 hours of additional education with the online learning platform within the first 30 days of employment. The Business Office Director will schedule	04/14/2023

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	employees. On 03/15/23, the Business Office Director provided the completed form with the following information: Employee #5 Employee #5 was hired as Medication Technician/Caregiver with a start date of 12/14/22. Employee #5's personnel file contained documented evidence of 2.5 hours of initial caregiver training within 60 days of hire. Employee #6 Employee #6 was hired as Medication Technician/Caregiver with a start date of 07/08/22. Employee #6's personnel file lacked documented evidence of initial caregiver training within 60 days of hire. Employee #7 Employee #7 was hired as Medication Technician/Caregiver with a start date of 10/28/22. Employee #7's personnel file contained documented evidence of 2.5 hours of initial caregiver training within 60 days of hire. Employee #8 Employee #8 was hired as Medication Technician/Caregiver with a start date of 10/28/22. Employee #8's personnel file contained documented evidence of 2 hours of initial caregiver training within 60 days of hire. On 03/15/23 at 2:23 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/15/23, confirming the Business Office Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2		all new Caregivers for General Orientation upon hire, the Wellness Director will schedule initial training following the General Orientation. Documentation of training will be completed weekly with each new hire per the Quality Assurance Review Schedule – Health Services. Training records will be reviewed monthly by the Business Office Director following the Quality Assurance Review Schedule – Business Office.	
1540 SS= E	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have	1540	Employee # 2, #7, #10 have completed the cultural competency training. Employee #10 is no longer employed at Arbors. Last scheduled day 02/23/2023 An audit of employee records was previously completed and employees who had not completed the training were scheduled to complete the course. As of March 2023, all employees had completed the training. The Business Office Director will schedule	04/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8994	A. BUILDING _____ B. WING _____	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS MEMORY CARE	2121 EAST PRATER WAY, SPARKS, NEVADA ,89434

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	different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed within 30 business days of being hired for 3 of 10 sampled employees required to obtain cultural competency training (Employees #2, #7, and #10). Findings include: On 03/15/23, the Business Office Director was provided the Personnel Check List to complete for 10 sampled employees. On 03/15/23, the Business Office Director provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Wellness Coordinator with a start date of 03/22/21. Employee #2's personnel file contained a cultural competency training certificate dated 07/21/22. Employee #7 Employee #7 was hired by the facility on as Medication Technician/Caregiver with a start date of 10/28/22. Employee #7's personnel file contained a cultural competency training certificate dated 01/27/23. Employee #10 Employee #10 was hired by the facility as Medication Technician/Caregiver with a start date of 02/09/21. Employee #10's personnel file lacked documented evidence of cultural competency training. On 03/15/23 at 2:23 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/15/23, confirming the Business Office Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2		and monitor completion within thirty days for all new hires. Training records will be reviewed monthly by the Business Office Director following the Quality Assurance Review Schedule – Business Office.	