Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey and complaint investigation #137719 for the above named facility conducted on 10/29/19 and 10/30/19.	S 000		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (a) The facility reported a census of 22 residents. The facility identified 19 residents with facility managed medications. The sample included 3 residents and 2 focused closed record reviews. Based on record review and interview the administrator/operator failed to ensure licensed nurses and certified medication aides	S3200		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3200	Continued From page 1	S3200		

administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for 1 of 3 sampled residents #289.

Findings included:

- On 10/29/19 licensed nurse A provided a resident roster which identified resident #289 received facility managed medications and had insulin managed by the facility.

The significant change functional capacity screen dated 2/15/19 identified the resident as unable to manage her own medications.

The negotiated service agreement/health service plan (NSA/HSP) dated 2/15/19 directed staff to perform blood glucose testing for the resident 4 times a day. Staff may assist with preparation of insulin pen and resident would self-inject. The NSA/HSP failed to direct staff to administer all the resident's medications.

Record review revealed a medication administration record (MAR) for October 2019 which included the initials of facility certified staff administration of the resident's medications. Comparison of the 8/08/19 signed recapitulation of the medical care provider's written orders and all subsequent orders with the October 2019 MAR revealed the MAR included PRN (as needed) medications which were not on the signed orders dated 8/08/19 or subsequent orders as follows:
acetaminophen 500 milligrams (mg) 2 tablets every 4 hours PRN pain
biotene mouth spray 1 spray once a day PRN for dry mouth
bisacodyl 10 mg suppository, rectally if no results

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3200	Continued From page 2	S3200		

from 2 doses of milk of magnesia
enema ready to use PRN if no results from the bisacodyl suppository
hemorrhoidal ointment topically to hemorrhoids PRN
calmoseptine ointment topically to affected area PRN may keep at bedside.

The medical care provider's written orders signed 8/08/19 included orders for staff to hold propranolol 40 mg twice a day for hypertension if the resident's pulse was less than 50 or greater than 100.

Review of the October 2019 MAR revealed no documentation of staff checking the resident's pulse before administration of the propranolol twice a day. The medical record included a monthly vital signs sheet.

Interview on 10/29/19 at 12:00 PM with licensed nurse A confirmed the discrepancies with the written orders and the October 2019 MAR. She reported an expectation for a nurse to compare a newly signed recapitulation of orders to the previously signed orders and to obtain clarification for any discrepancies. She confirmed the order to obtain a pulse prior to administration of the propranolol and the record lacked evidence of the staff following this medical care provider's written order.

The administrator/operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for this resident regarding pulse perimeters for an hypertensive medication and discrepancies with the current recapitulation of signed orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) (4)	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3215	Continued From page 4 The facility reported a census of 22 residents. The facility identified 19 residents with facility managed medications. The sample included 3 residents and 2 focused closed record reviews. Based on observation, record review and interview the administrator/operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened for 2 of 2 residents whose insulin the facility managed (#289 and #313). Findings included: - On 10/29/19 licensed nurse A provided a resident roster which identified resident #289 received facility managed medications and had insulin managed by the facility. The significant change functional capacity screen dated 2/15/19 identified the resident as unable to manage her own medications. The negotiated service agreement/health service plan dated 2/15/19 directed staff to perform blood glucose testing for the resident 4 times a day. Staff may assist with preparation of insulin pen and resident would self-inject. Observation on 10/29/19 at 9:32 AM of the medication room with cabinets for medication storage revealed an open and used Tresiba insulin pen for resident #289 without a date of opening. Interview on 10/29/19 at 9:35 AM with certified medication aide B confirmed she would dial the	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3215	Continued From page 5 dose of the prescribed insulin and had the pen to the resident for self-injection. She was unaware of the need to date the insulin pens when opened to ensure the insulin was used before the manufacture recommended storage time after opening. Interview on 10/29/19 at 9:35 AM with licensed nurse A confirmed the Tresiba insulin pen was opened and used. She was unaware of the need to date the insulin pens when opened or of the recommended storage time after opening. The manufacture of Tresiba recommended to store in-use Tresiba at room temperature (below 86 degrees Fahrenheit), away from direct heat and light for up to 8 weeks without refrigeration and do not refrigerate once opened. The administrator/operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration regarding insulin pens once opened. - On 10/29/19 licensed nurse A provided a resident roster which identified resident #313 received facility managed medications and had insulin managed by the facility. The annual functional capacity screen dated 7/25/19 identified the resident as unable to manage her own medications. The negotiated service agreement/health service plan dated 7/25/19 directed staff to perform blood glucose testing for the resident twice a day but failed to identify facility management of medications and specifics for insulin	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3215	Continued From page 6 administration. Observation on 10/29/19 at 9:32 AM of the medication room with cabinets for medication storage revealed an open and used Novolog insulin pen for resident #313 without a date of opening. Interview on 10/29/19 at 9:35 AM with certified medication aide B confirmed she would dial the prescribed dose of the Novolog insulin pen, and the resident would self-inject. She was unaware of the need to date the insulin pens when opened or of the recommended discard 28 days after opening. Interview on 10/29/19 at 9:35 AM with licensed nurse A confirmed the Novolog insulin pen was opened and used. She was unaware of the need to date the insulin pens when opened or of the recommended discard 28 days after opening. The Novolog Flex pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained. The administrator/operator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration regarding insulin pens once opened.	S3215		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3248	Continued From page 7 documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (d) (1) (3) The facility reported a census of 22 residents. Based on interview and record review the administrator/operator failed to have evidence of she or a designated staff checked with the nurse aide registry for 3 of 4 certified nurse aides/certified medication aides (CNA/CMA) hired since last resurvey prior to him/her providing care for the residents (CNA C, CMA D and CMA E. The administrator/operator also failed to have evidence of criminal background checks for 2 of 4	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3248	Continued From page 8 CMA/CNAs hired since last survey (CNA C and CMA E). All 3 employees had the potential to provide care to all the residents. Findings included: - Personnel record review on 10/29/19 at 2:25 PM revealed the following: Certified nurse aide C began employment on 1/25/19. The file included a registry verification without a date stamp to indicate the registry was verified before the CNA began providing cares to residents. The file included an authorization to check the criminal background completed by the employee and no evidence of a submission to have the criminal background check to ensure the CNA did not have a prohibited finding of abuse/neglect/exploitation. Certified medication aide (CMA) D began employment on 8/02/19. The file included a registry verification without a date stamp to indicate the registry was verified before the CNA began providing cares to residents. CMA E began employment on 5/20/19. The file included a registry verification without a date stamp to indicate the registry was verified before the CNA began providing cares to residents. The file included information from a previous employment with the facility dated 5/29/18. Interview on 10/29/19 at 4:00 PM with administrator/operator F revealed CMA E had a break in employment between 5/29/18 and 5/20/19 but she did not provide specific dates. CMA E's file also lacked evidence of a criminal background check for the re-employment date of 5/20/19.	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3248	Continued From page 9 Interview on 10/29/19 at 2:25 PM with business office manager G confirmed the registry verifications lack the date stamp of when there were verified, and the files only had the employee's authorization to check the criminal background with no evidence of submission to have the criminal background check to ensure the CMA did not have a prohibited finding of abuse/neglect/exploitation. The administrator/operator failed to have evidence of verifying the nursing license for licensed nurse/operator E at the time of employment. The facility also failed to check with the nurse aide registry for 2 of 4 CNA/CMAs hired since last resurvey prior to him/her providing care for the residents and failure to submit a request for a criminal background check on 2 of 4 CNA/CMAs hired since last resurvey to ensure the CNA/CMA did not have a prohibited finding of abuse/neglect/exploitation. All 3 employees had the potential to provide care to all the residents.	S3248		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (a)	S3265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3265	Continued From page 10 The facility reported a census of 22 residents with 5 having impaired cognitive function. Based on record review and interview the administrator/operator failed to ensure the annual emergency evacuation drill with the least amount of staff on duty could be completed in the timeframe set by the fire marshal to ensure the provision of a sufficient number of staff members needed to take residents who would require assistance in an emergency or disaster to a secure location. Findings included: - On 10/29/19 licensed nurse A provided the resident roster which identified 5 of 22 residents with cognitive impairment. During the entrance conference on 10/29/19 at 10:00 AM administrator/operator F reported staffing the residential health care with 1 staff member during the overnight hours. On 10/29/19 administrator/operator F provided 2 documents for the annual evacuation of the facility with 1 conducted on 8/31/19 at 11:00 PM and 1 conducted on 9/30/19 at 10:30 AM. The document dated 8/31/19 at 11:00 PM indicated the facility census was 22 residents and that all residents were evacuated out the dining room exit or outside room door. The document included a signature of 1 staff conducting the evacuation which took 8 minutes. The fire marshal established an evacuation time of 3 minutes for a facility which do not have a sprinkler/fire suppression system. The document dated 9/30/19 at 10:30 AM indicated the facility census was 20 residents and	S3265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001007	A. BUILDING: _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWOOD LANE	615 E FRANKLIN HUMBOLDT, KS 66748

(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) COMPLETE DATE
S3265	Continued From page 11 all were evacuated by all exits in 4 minutes with 3 staff members participating in the evacuation. Interview with maintenance personnel H on 10/29/19 at 12:00 PM confirmed the facility did not have a sprinkler/fire suppression system. Interview with administrator/operator F on 10/29/19 at 12:22 PM revealed the 8/31/19 evacuation drill was conducted by 1 staff member and took 8 minutes. She was not aware of the 3-minute time frame as allowed by the fire marshal for facilities without a sprinkler/fire suppression system and confirmed the facility did not have a sprinkler/fire suppression system. The administrator/operator failed to ensure the annual emergency evacuation drill with the least amount of staff on duty could be completed in the timeframe set by the fire marshal to ensure the provision of a sufficient number of staff members needed to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		