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	0014935	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISION HOME LLC II	1449 N GREEN BAY ROAD MOUNT PLEASANT, WI 53406

(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
N 000	Initial Comments On 01/26/2024, with information gathered through 02/07/2024, Surveyor conducted an abbreviated survey and a complaint investigation. As a result, 8 deficiencies were identified. The complaint was substantiated. Census: 7	N 000		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all employee records were maintained and current for 1 of 2 employees reviewed. House Manager C's record did not include documentation of training for orientation, resident rights, dietary, and personal care training. Findings include: On 01/26/2024, Surveyor reviewed House Manager C's record. House Manager C was hired 05/24/2018. House Manager C's record did not include documentation of orientation training,	N 223		

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

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N 223	Continued From page 1 resident rights training, dietary training, or personal care training. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A. Licensee A reported s/he kept employee documentation in his/her home office. Licensee A reported s/he had experienced a house fire since House Manager C was hired and believed some of the documents were destroyed. Licensee A reported s/he would ensure a system to safeguard all files in the future.	N 223		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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N 239	Continued From page 2	N 239		

This Rule is not met as evidenced by:
Based on record review, interview, and observation, the provider did not ensure 1 of 2 employees obtained all department approved training as required.

Caregiver D did not have training in fire safety within 90 days after starting employment.

Caregiver D did not have training in first aid and choking within 90 days after starting employment.

Caregiver D, who had responsibilities for medication administration, did not have training in medication administration and management prior to assuming these duties.

Caregiver D, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties.

Findings include:

On 01/26/2024, Surveyor reviewed employee records to verify compliance with department approved training requirements. Surveyor requested training records from Licensee A for Caregiver D. Caregiver D was hired on 05/14/2021. The following was identified:

Fire Safety

Caregiver D's record did not contain evidence of training or evidence of meeting an exemption for

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N 239	Continued From page 3 fire safety. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed the provider did not have evidence Caregiver D completed or met an exemption for fire safety training. Licensee A reported his/her ex-business partner was a trainer and was responsible for training staff and entering their information on the registry. Licensee A reported s/he did not know why Caregiver D was not on the training registry. On 01/26/2024, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for fire safety. First Aid and Choking Caregiver D's record did not contain evidence of training or evidence of meeting an exemption for first aid and choking training. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed the provider did not have evidence Caregiver D completed or met an exemption for first aid and choking. Licensee A reported his/her ex-business partner was a trainer and was responsible for training staff and entering their information on the registry. Licensee A reported s/he did not know why Caregiver D was not on the training registry. On 01/26/2024, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for first aid and choking. Medication Administration	N 239		

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N 239	Continued From page 4 On 01/26/2024, at 12:20 PM, Surveyor observed Caregiver D provide torsemide 20 milligram tablets (2 tablets) and ferrous sulfate 325 mg to Resident 2. Caregiver D reported s/he had been trained to provide medications by the nurse who was contracted with the provider. Caregiver D did not mention information relating to the training registry. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed Caregiver D was responsible for medication administration duties. Licensee A confirmed the provider did not have evidence Caregiver D completed or met an exemption for medication management training prior to assuming these job duties. Licensee A reported his/her ex-business partner was a trainer and was responsible for training staff and entering their information on the registry. Licensee A reported s/he did not know why Caregiver D was not on the training registry. On 01/26/2024, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for medication administration. Standard Precautions On 01/26/2024, at approximately 12:30 PM, Surveyor interviewed Caregiver D. Caregiver D reported s/he was responsible for checking a resident's blood glucose level routinely. Caregiver D reported s/he had standard precautions training annually. Caregiver D was unsure about the training registry. Caregiver D's record did not contain evidence of	N 239		

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N 239	Continued From page 5 training or evidence of meeting an exemption for standard precautions. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed Caregiver D performed job tasks that may expose the employee to blood or other bodily fluids. Licensee A confirmed the provider did not have evidence Caregiver D completed or met an exemption for standard precaution training prior to assuming these job duties. On 01/26/2024, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for standard precautions. Licensee A was given the opportunity to submit any additional evidence of training by 01/29/2024. No evidence Caregiver D completed the department approved training courses required was provided to Surveyor.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights	N 243		

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N 243	Continued From page 6 training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 2 of 2 employees reviewed, obtained all training as required within 90 days after starting employment. House Manager C and Caregiver D did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment.	N 243		

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N 243	Continued From page 7 House Manager C and Caregiver D did not have training in required client groups within 90 days after starting employment. Findings include: Recognizing, Preventing, Managing and Responding to Challenging Behaviors On 01/26/2024, Surveyor reviewed employee records and identified the following: -The record for House Manager C, hired 05/24/2018, did not contain evidence of training or meeting an exemption for challenging behaviors training. -The record for Caregiver D, hired 05/14/2021, did not contain evidence of training or meeting an exemption for challenging behaviors training. On 01/26/2024, at approximately 11:00 AM, Surveyor interviewed Licensee A. Licensee A confirmed the provider did not have evidence House Manager C and Caregiver D completed or met an exemption for challenging behaviors training. Client Group The facility was licensed to provide care and services to residents within the client groups of correctional clients, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, advanced age, alcohol/drug dependent, irreversible dementia/Alzheimer's, and terminally ill. On 01/26/2024, Surveyor reviewed employee records and identified the following: -The record for House Manager C, hired	N 243		

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N 243	Continued From page 8 05/24/2018, did not contain evidence of training or meeting an exemption for client group training. -The record for Caregiver D, hired 05/14/2021, did not contain evidence of training or meeting an exemption for client group training. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed the provider did not have evidence House Manager C and Caregiver D completed or met an exemption for client group training specific to correctional clients, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, advanced age, alcohol/drug dependent, irreversible dementia/Alzheimer's, and terminally ill. Licensee A reported the residents in the facility currently had dementia, mental illness, developmental disabilities, and alcohol dependence. Licensee A was given the opportunity to submit any additional evidence of training by 01/29/2024. Licensee A provided a training titled 'Cultural Competency' for Caregiver D but did not submit further evidence of the specific client group training of residents served in the facility.	N 243		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and	N 277		

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N 277	Continued From page 9 misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each caregiver received 15 hours of continuing education for 2 of 2 employees reviewed in 2022 and 2023. House Manager C and Caregiver D received less than 15 hours of continuing education in 2022 and 2023. Findings include: On 01/26/2024, Surveyor reviewed employee records and identified the following: - House Manager C was hired 05/24/2018. House Manager C's record identified his/her continuing education for 2022 totaled 8 hours. House Manager C's record identified his/her continuing education for 2023 totaled 13 hours. -Caregiver D was hired 05/14/2021. Caregiver D's record identified his/her continuing education for 2022 totaled 13 hours. Caregiver D's record identified his/her continuing education for 2023 totaled 13 hours. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A. Licensee A reported s/he knew of the topics required for annual continuing education. Licensee A reported s/he had thought his/her service providers had enough continuing education hours logged in 2022 and 2023. Licensee A reported s/he would ensure s/he scheduled his/her staff more hours of training in the future.	N 277		

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N 381	Continued From page 10	N 381		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 1 of 1 resident was assessed for risk of falls. Resident 1 was not assessed for fall risk prior to/upon admission on 04/03/2023, or after a fall on 05/12/2023. On 06/24/2023, Resident 1 fell out of bed and went to the hospital. Resident 1 did not return to the facility. Findings include: On 06/27/2023, the department received a complaint alleging the provider was unable to provide the level of care a resident needed. On 01/29/2024, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted on 04/03/2023, with diagnoses including dementia and mild cognitive impairment. -Resident 1's admission assessment, dated	N 381		

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N 381	Continued From page 11 03/09/2023, did not assess fall risk. -Resident 1's admission information from the managed care organization, located in Resident 1's record, dated 03/01/2023, identified Resident 1 had a history of falls and was unable to live independently due to fracturing his/her hip after a fall in December 2022. Resident 1 was admitted to the facility from the hospital after his/her recovery. The assessment stated, "Daily Living Skills: Due to recent fall resulting in hip dislocation, chronic back pain, chronic fatigue, dementia, poor balance and dizziness, member requires assistance and cues with the following ADLs (activities of daily living). Member is fall risk and has history of falls...Mobility: Member needs reminders to use [his/her] walker at all times." -Resident 1's incident report, dated 05/12/2023, timestamped 5:33 AM, identified Resident 1 had a fall and went to the hospital for evaluation. The incident report stated, "[Resident 1] woke up to use the bathroom when [s/he] was in the bathroom, before [s/he]...came out [s/he][fell face down on [his/her] face. Due to [him/her] falling, it left bruise on [his/her] right side of...face..." -Resident 1's after visit summary, dated 05/12/2023, identified Resident 1 had a computerized tomography (CT) scan which showed fluid around the brain. The AVS stated, "CT scan showed a small collection of fluid around the brain. This could be from bleeding, but it would have occurred sometime ago, not today and likely not even last week. Please do not take blood thinner Eliquis." -Resident 1's record identified there was no fall assessment completed after the 05/12/2023 fall. On 02/07/2024, at 3:30 PM, Surveyor interviewed Licensee A and Administrator B. Administrator B reported it was his/her responsibility to assess residents prior to and after admission when	N 381		

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N 381	Continued From page 12 needed. Administrator B reported s/he did not routinely assess all residents for fall risk unless there was a known risk for falls. Administrator B confirmed s/he did not assess Resident 1 for risk of falls and could not recall if s/he was at risk of falling. Administrator B reported s/he was unable to recall the needs of Resident 1 and could not recall when s/he had fall assessments completed. Licensee A reported all information in Resident 1's file was complete and if it was not present, then they did not have the assessments. Licensee A reported the provider did not have a policy or procedure for when assessments were to be completed.	N 381		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident had a comprehensive individualized service plan (ISP).	N 386		

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Resident 1's ISP did not include information regarding Resident 1's, care needs, risk of falls, and interventions to prevent further falls.

Findings include:

On 06/27/2023, the department received a complaint alleging the provider was unable to provide the level of care a resident needed.

On 01/29/2024, Surveyor reviewed Resident 1's record and identified the following:
-Resident 1 was admitted on 04/03/2023, with diagnoses including dementia and mild cognitive impairment.
-Resident 1's admission assessment, dated 03/09/2023, did not assess fall risk.
-Resident 1's admission information from the managed care organization, located in Resident 1's record, dated 03/01/2023, identified Resident 1 had a history of falls and was unable to live independently due to fracturing his/her hip after a fall in December 2022. Resident 1 was admitted to the facility from a residential care apartment complex due to needing a higher level of care. The assessment stated, "Daily Living Skills: Due to recent fall resulting in hip dislocation, chronic back pain, chronic fatigue, dementia, poor balance and dizziness, member requires assistance and cues with the following ADLs (activities of daily living). Member is fall risk and has history of falls. BATHING: Member needs assistance getting in/out of the shower and washing/drying self for [s/he] has history of ongoing dizziness putting [him/her] at risk for falls. DRESSING: Due to hip pain, member needs assistance with putting on [his/her] socks and shoes r/t (related to) inability to bend more than 90 degree in risk of dislocating [his/her] hip...MOBILITY: Member needs reminders to use

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NEW VISION HOME LLC II	1449 N GREEN BAY ROAD MOUNT PLEASANT, WI 53406

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N 386	Continued From page 14 [his/her] walker at all times. TOILETING: Member would need assistance with clean up after bowel accidents due to inability to reach or bend due to pain. Transfer: Member needs assistance and verbal cues to get in/out of [his/her] bed...Mobility and Transfers...needs reminders to use [his/her] dme [sic] (durable medical equipment) when walking around the facility." -Resident 1's incident report, dated 05/12/2023, timestamped 5:33 AM, identified Resident 1 had a fall and went to the hospital for evaluation. The incident report stated, "[Resident 1] woke up to use the bathroom when [s/he] was in the bathroom, before [s/he]...came out [s/he][fell face down on [his/her] face. Due to [him/her] falling, it left bruise on [his/her] right side of...face..." There was no information on whether Resident 1's walker was nearby or if Resident 1 was asked what happened. -Resident 1's incident report, dated 06/08/2023, timestamped 6:25 PM, identified Resident 1 had a fall. The incident report stated, "[A resident] said [s/he] heard [Resident 1] bump the wall and when [s/he] went to see what happened [s/he] was in [sic] the floor between the wall and bed. [S/He] stated to me [s/he] wasn't hurt. No visible injuries but [s/he] states [his/her] right hand was tingling. Light bruising on inside of right hand close to pinky finger. There was no information regarding whether Resident 1's walker was nearby or if Resident 1 was asked what happened. -Resident 1's fall risk assessment, dated 06/09/2023, stated, "Summary: Indicate fall risk potential, identifying factors that can be managed, controlled or removed by staff intervention. If fall risk potential exists take to care planning. Include interventions that manage, control or remove the risk factors identified...All of [Resident 1's] falls have been due to loss of balance and/or not using [his/her] walker. Staff should remind	N 386		

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N 386	Continued From page 15 [Resident 1] to always use [his/her] walker and when able, walk with [Resident 1] to ensure [s/he] doesn't fall. Remind [Resident 1] to ask for help when needed." The assessment was completed by Administrator B. -Resident 1's ISP, dated 04/03/2023, identified Resident 1 required the use of a walker. Resident 1's ISP did not include information regarding Resident 1 requiring any staff assistance with toileting, bathing, dressing, mobility, or transfers. There was no mention Resident 1 was at risk of falls, or what interventions staff needed to assist Resident 1 with to reduce the risk of falling. There was no information or instructions on when Resident 1 needed to use the walker. There were no updates made to the ISP after Resident 1 had fallen on 05/12/2023 and 06/08/2023. On 02/07/2024, at 3:30 PM, Surveyor interviewed Licensee A and Administrator B. Licensee A reported when a resident had a change of condition, they completed a change of condition form and left it in the office for staff. Licensee A reported if there was a change to the ISP, they would write the change on the ISP and date it. Licensee A reported s/he would send a change of condition form if any were located for Resident 1. Administrator B reported it was his/her responsibility to create and update the ISPs for all residents. Administrator B confirmed Resident 1's ISP was not updated after the falls. Administrator A reported there was no provider policy or procedure regarding instructions for when the ISPs needed to be updated. Administrator B reported staff knew how to work with the residents by training by the house manager. Administrator B reported s/he did not know Resident 1 was at risk of falls when s/he was first admitted. Administrator B confirmed Resident 1 lost his/her balance and that's why s/he fell.	N 386		

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N 386	Continued From page 16 Administrator B confirmed the ISP did not include interventions to reduce falls or include information Resident 1 required reminders. Administrator B could not recall all details of what Resident 1 required since s/he left the facility at the end of June 2023. Administrator B confirmed Resident 1's ISP did not detail the specific interventions Resident 1 required for care needs. Licensee A and Administrator B would review all ISPs to ensure they were comprehensive and included current interventions for all residents residing in the facility. As of 02/12/2024, Surveyor did not receive any additional information from the provider.	N 386		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need	N 404		

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N 404	Continued From page 17 physician involvement to address. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure a physician, pharmacist, or registered nurse conducted a review of the provider's medication administration and storage system annually for 2 of 2 years reviewed (2022 and 2023). Findings include: On 01/26/2024, Surveyor reviewed the provider's safety records. There were no reviews of the provider's medication administration and storage system to review. Surveyor requested the documentation from Licensee A and Administrator B. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A and Administrator B. Licensee A reported s/he did not know of the requirement to have the medication administration and storage system reviewed annually. Licensee A confirmed reviews had not been completed in 2022 and 2023. Licensee A reported s/he contracted with a registered nurse who made visits to the facility monthly to review residents' charts and provided consultation when needed. Licensee A reported s/he would talk with his/her contracted nurse and the pharmacy to see how s/he could ensure the medication administration and storage system was audited annually moving forward.	N 404		
N 525	83.47(2)(d) Fire drills.	N 525		

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N 525	Continued From page 18 Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the fire drill documentation included the date and time of the drills conducted or a drill which simulated conditions was completed for 2 of 2 years reviewed (2022 and 2023). Findings include: The provider was licensed as a Class CNA (non-ambulatory) community based residential facility (CBRF) on 01/05/2015 to serve up to 8 residents in the client groups of correctional clients, traumatic brain injury, developmentally disabled, physically disabled, emotionally disturbed/mental illness, advanced age, alcohol/drug dependent, irreversible dementia/Alzheimer's, and terminally ill.	N 525		

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N 525	Continued From page 19 On 01/26/2024, Surveyor reviewed safety records. Fire drill documentation did not contain the date or time of the drills. There was no identified fire drill in 2022 and 2023 which simulated conditions during the night. The following was identified: 2022 Fire Drills -01/14/2022-"Time: AM" -03/14/2022-"Time: AM" -07/30/2022-"Time: AM" -09/21/2022-"Time: AM" -10/21/2022-"Time: 1PM" -There was no documentation a drill which simulated conditions during sleeping hours was completed. 2023 Fire Drills -01/2023-"Time: AM" -04/2023-"Time: AM" -08/2023-"Time: AM" -11/2023-"Time: AM" -There was no documentation a drill which simulated conditions during sleeping hours was completed. The specific dates and times of the fire drills were not documented. On 01/26/2024, at approximately 1:00 PM, Surveyor interviewed Licensee A and Administrator B. Licensee A reported s/he was present when drills were conducted to ensure staff and residents were knew how to complete the drills safely. Licensee A reported s/he had recently changed the way s/he documented fire drills as of 2024. Licensee A reported a new fire drill had not yet been completed at the facility, but s/he had plans to use the new form which would include specific dates and times of drills. Licensee A recently learned s/he needed to keep	N 525		

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N 525	Continued From page 20 documentation of dates and times of drills. Licensee A reported s/he did not know of the requirement to complete a fire drill which simulated conditions during sleeping hours annually. Licensee A reported s/he would implement the correction as soon as possible.	N 525		