STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016630	A. BUILDING: _____ B. WING _____	R-C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA OF GREENFIELD	8765 W FOREST HOME AVE GREENFIELD, WI 53228

(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 08/12/2024, Surveyors completed a standard survey, one verification visit, and four complaint investigations at Villa of Greenfield. As a result, the two previous deficiencies were corrected, and twelve new deficiencies were identified. One complaint was substantiated, and three complaints were unsubstantiated. Under statutory provisions of WIS. State CH 50, a $200 revisit fee is assessed. Census: 31	{N 000}		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, a registered nurse or a physician's assistant indicating 3 of 4 caregivers reviewed were screened for clinically apparent	N 220		

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

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N 220	Continued From page 1 communicable diseases within 90 days before the start of employment. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) YTQ413 dated 03/24/2023, SOD YQT412, dated 10/21/2022, and SOD UXEE11, dated 01/16/2020. Findings include: On 08/12/2024, at approximately 12:00 PM, Surveyors reviewed staff records and identified the following: Caregiver C was hired on 11/07/2017. Caregiver C's record did not contain evidence indicating Caregiver C was screened for apparent communicable disease. Caregiver KK was hired on 01/10/2024. Caregiver KK's record did not contain evidence indicating Caregiver KK was screened for apparent communicable disease. Caregiver LL was hired on 03/18/2024. Caregiver LL's record did not contain evidence indicating Caregiver LL was screened for apparent communicable disease. On 08/12/2024, at 1:00PM Surveyors interviewed Nurse Y. Nurse Y reported s/he completed all tuberculosis tests for staff. Nurse Y confirmed s/he did not complete communicable disease screening. Nurse Y reported s/he would ensure all communicable disease screening was completed in the future.	N 220		

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N 230	Continued From page 2	N 230		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 4 staff reviewed received orientation in the required topics prior to performing job duties. Prior to performing job duties, Caregiver KK and Caregiver LL did not receive orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures; and recognizing and responding to resident changes of condition. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 42 residents in client groups of physically disabled,	N 230		

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N 230	Continued From page 3 advanced aged and irreversible dementia/Alzheimer's. On 08/12/2024, at 12:00 PM, Surveyors conducted a review of employee files to verify compliance with orientation training requirements. Surveyors reviewed training records and identified the following: Example 1- Caregiver KK was hired on 01/10/2024. Caregiver KK's record did not contain evidence of orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures; and recognizing and responding to resident changes of condition prior to performing job duties. Example 2- Caregiver LL was hired on 03/18/2024. Caregiver LL's record did not contain evidence of orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures; and, recognizing and responding to resident changes of condition prior to performing job duties. On 08/12/2024, at 3:00 PM, Surveyors interviewed Administrator M. Administrator M reported s/he was not aware of the timeline for the trainings. Administrator M reported they had trainings conducted every month. Administrator M confirmed Caregiver KK and Caregiver LL had performed job duties prior to orientation training.	N 230		

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N 243	Continued From page 4	N 243		
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 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	N 243		

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N 243	Continued From page 5 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 1 of 4 employees reviewed, obtained all training as required within 90 days after starting employment. Caregiver KK did not have training in responding to challenging behaviors within 90 days after starting employment. Caregiver KK did not have training in required client groups within 90 days after starting employment. This is a repeat deficiency. See Statement of Deficiency (SOD) YQT412, dated 10/21/2022. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 42 residents in client groups of physically disabled, advanced aged and irreversible dementia/Alzheimer's. On 08/12/2024, at 12:00 PM, Surveyors reviewed employee records and identified the following: Recognizing, Preventing, Managing and Responding to Challenging Behaviors	N 243		

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N 243	Continued From page 6 Caregiver KK was hired on 01/10/2024. Caregiver KK's record did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. Client Group The facility was licensed to provide care and services to residents within the client groups of physically disabled, advanced aged and irreversible dementia/Alzheimer's. Caregiver KK was hired on 01/10/2024. Caregiver KK's record did not contain evidence of training or evidence of meeting an exemption for client group training. On 08/12/2024, at 3:00 PM, Surveyor interviewed Administrator M. Administrator M reported s/he was not aware of the timeline for the trainings. Administrator M reported they had trainings conducted every month.	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 misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

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N 277	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees received continuing education in all required topics in 2023. Caregiver C and Caregiver P did not receive continuing education training in standard precautions, medications, fire safety and emergency procedures including first aid for 2023. Findings include: On 08/12/2024, at 12:00 PM, Surveyors reviewed employee files and identified the following: Caregiver C was hired 11/07/2017. Caregiver C's record did not contain evidence of continuing education training in standard precautions, medications, fire safety and emergency procedures including first aid for 2023. Caregiver C's training record did not indicate the total number of continuing education hours Caregiver C completed. Caregiver P was hired 04/15/2024. Caregiver P's record did not contain evidence of continuing education training in standard precautions, medications, fire safety and emergency procedures including first aid for 2023. Caregiver P's training record did not indicate the total number of continuing education hours Caregiver P completed. On 08/12/2024, at 3:00 PM, Surveyors interviewed Administrator M. Administrator M confirmed s/he was aware of the continuing education trainings required annually. Administrator M reported Former Consultant MM	N 277		

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N 277	Continued From page 8 trained staff and utilized the attestation form. Administrator M reported s/he was unaware of the missing topics. Administrator M reported the training lasted a few hours and confirmed the training did not last 15 hours.	N 277		
N 382	83.35(1)(b) Sources used for assessment information. Information gathering. The CBRF shall base the assessment on the current diagnostic, medical and social history obtained from the person ' s health care providers, case manager and other service providers. Other service providers may include a psychiatrist, psychologist, licensed therapist, counselor, occupational therapist, physical therapist, pharmacist or registered nurse. The administrator or designee shall hold a face-to-face interview with the person and the person ' s legal representative, if any, and family members, as appropriate, to determine what the person views as his or her needs, abilities, interests, and expectations. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct a face-to-face assessment for 3 of 4 residents (Resident 26, Resident 27, and Resident 28) to determine what the resident viewed as his or her needs, abilities, interests, and expectations. Findings include: On 08/12/2024, at 7:00 AM, Surveyors reviewed the providers facility folder. Surveyors did not review a waiver request to not conduct face to face assessments.	N 382		

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N 382	Continued From page 9 On 08/12/2024, at 11:30 AM, Surveyors reviewed resident record's and identified the following: -Resident 26 was admitted on 05/20/2024. Resident 26's record did not contain a written pre-admission assessment. -Resident 27 was admitted on 01/18/2024. Resident 27's record did not contain a written pre-admission assessment. -Resident 28 was admitted on 11/13/2023. Resident 28's record did not contain a written pre-admission assessment. On 08/12/2024 at 03:00 PM, Surveyors interviewed Administrator M and Nurse Y. Surveyors inquired about the process of how pre-admission assessments were conducted. Administrator M reported Nurse Y completed all pre-admission assessments by reviewing long term care screenings. Administrator M reported s/he or Nurse Y did not complete a face-to-face interview with the person and/or the person's legal representative. Nurse Y reported s/he was unaware of the requirement. Cross reference: DHS N0384 83.35(1)(d) Retain Written Report Of Assessment	N 382		
N 384	83.35(1)(d) Retain written report of assessment. Assessment documentation. The CBRF shall prepare a written report of the results of the assessment and shall retain the assessment in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the	N 384		

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N 384	Continued From page 10	N 384		

provider did not ensure a written report for 3 of 4 residents (Resident 26, Resident 27, and Resident 28) pre-admission assessment results were retained in their records.

Findings include:

On 08/12/2024, at 1:30 AM, Surveyors reviewed resident record's and identified the following:

-Resident 26 was admitted on 05/20/2024 with diagnoses including type 2 diabetes, major depressive disorder, congestive heart failure, hypertension, obstructive sleep apnea, chronic obstructive pulmonary disease, and acute and chronic respiratory failure with hypoxia. Resident 26's record did not contain a written pre-admission assessment.

-Resident 27 was admitted on 01/18/2024 with diagnoses including type 2 diabetes, Alzheimer's, stage 3 chronic kidney disease, klebsiella pnuemoniae, and depression. Resident 27's record did not contain a written pre- admission assessment.

-Resident 28 was admitted on 11/13/2023 with diagnoses including type 2 diabetes, Parkinson's, depressions, generalized anxiety disorder, chronic obstructive pulmonary disease, presence of automatic cardiac defibrillator, and heart disease. Resident 28's record did not contain a written pre-admission assessment.

On 08/12/2024 at 03:00 PM, Surveyors interviewed Administrator M and Nurse Y. Administrator M reported Nurse Y completed all pre-admission assessments by reviewing long term care screenings. Administrator M and Nurse Y confirmed they do not prepare a written report

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N 384	Continued From page 11 of the results of the assessment. Nurse Y reported s/he will utilize a form created by previous consultant. Cross reference: DHS N0382 83.35(1)(b) Sources Used For Assessment Information	N 384		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 3 medication carts were locked with a key available only to personnel identified by the community based residential facility (CBRF). The medication cart, which stored residents' scheduled medications, was unlocked for 32 minutes. The medication cart, which stored residents' as needed medications, was unlocked for 110 minutes. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 42 residents in client groups of physically disabled, advanced aged and irreversible dementia/Alzheimer's. On 08/12/2024, at 8:30 AM, Surveyors toured the facility and observed the medications carts. The medication cart which stored residents as needed medications was unlocked. The cart contained a locking mechanism, the locking mechanism was not engaged. The cart was	N 419		

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N 419	Continued From page 12 unlocked for 110 minutes. The medication cart which stored residents' scheduled medications was unlocked. The cart contained a locking mechanism, the locking mechanism was engaged. When Surveyors pulled on the drawers, the drawers opened. The cart was unlocked for 32 minutes. Residents were observed moving freely throughout the facility. On 08/12/2024, at 3:00 PM, Surveyors interviewed Administrator M. Administrator M confirmed medications should have been securely stored. Administrator M was unaware of the broken locking mechanism. Administrator M reported s/he would ensure the cart was replaced immediately.	N 419		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence.	N 425		

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N 425	Continued From page 13	N 425		

This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not ensure 2 of 2 residents, (Resident 7 and Resident 23), received assistance with personal cares. Resident 7's hair appeared greasy. Resident 23 did not receive incontinent assistance as directed in Resident 23's individual service plan.

Findings include:

On 04/09/2024, the department received a complaint alleging residents were not receiving assistance with personal cares.

Observations

On 08/12/2024, at 8:30 AM, Surveyors toured the facility. Surveyors observed Resident 7 at the dining room table. Resident 7's hair appeared greasy. Surveyors observed Resident 7 at 10:12 AM at the dining room table, her/his shirt was covered in what appeared to be food particles. At 12:30 PM, Surveyors observed Resident 7. Resident 7's clothing had been changed, Resident 7's hair still appeared to be greasy.

Interviews

On 08/12/2024, at 8:50 AM, Surveyors interviewed Caregiver P. Caregiver P reported resident showers were rarely completed if s/he was not working. Caregiver P reported residents were to be showered twice a week. Caregiver P reported when s/he worked, s/he tried to complete extra showers to ensure residents received their showers.

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N 425	Continued From page 14 On 08/12/2024, at 9:40 AM, Surveyors interviewed Resident 23. Resident 23 reported s/he needed assistance with toileting. Resident 23 reported s/he would pull her/his call light to alert staff s/he needed to be changed. Resident 23 reported s/he had experienced a "bowel issue" which caused her/his bowel movements to be softer than normal. Resident 23 stated, "When I pull the light, they turn off the light and then tell me they are going to find my staff, and then they forget about me." Resident 23 reported Caregiver P was the only person to give her/him a bath. On 08/12/2024, at 3:00 PM, Surveyors interviewed Administrator M and Senior Manager NN. Senior Manager NN and Administrator M reported Resident 23 had reported concerns before. Senior Manager NN reported they have coached staff when Resident 23 reported this earlier. Administrator M reported Resident 23 had started to develop behaviors regarding false accusations. When Surveyors inquired if Resident 23's behaviors were documented on her/his ISP, Administrator M reported they were not. Record Review On 08/12/2024, at 9:03 AM, Surveyors reviewed the shower schedule. Resident 7 was to have a shower twice a week, on Mondays and Thursdays on first shift. Resident 23 was to have a shower twice a week, on Tuesdays and Fridays on second shift. On 08/12/2024, at 2:45 PM, Surveyors reviewed Resident 23's individual service plan (ISP), dated 05/10/2024. Resident 23's ISP, under section "Toileting" stated, "Resident requires total assistance support including physical and verbal	N 425		

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	0016630	A. BUILDING: _____ B. WING _____	R-C 08/12/2024

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N 425	Continued From page 15 assistance with toileting needs and requires hands-on assistance with undressing/dressing, washing/wiping and any physical assistance necessary. [Resident 23] prefers to stay in bed and is incontinent therefore needs to be changed." Resident 23's ISP indicated Resident 23 should be toileted 12 times a day. Resident 23's ISP did not report any accusatory behaviors.	N 425		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored to prevent food borne illness. The provider did not properly seal food, maintain labels or dates on open food. This had the potential to affect 31 of 31 residents in	N 452		

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N 452	Continued From page 16 the facility. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) YQT414, dated 09/01/2023, SOD YQT412, dated 10/21/2022, and SOD UXEE11, dated 01/16/2020. Findings include: On 08/12/2024, at 10:11 AM, Surveyor toured the facility kitchen and observed the following: Kitchen refrigerators -bowl of breaded meat, unlabeled, unsealed, and undated. -plate of sliced yellow cheese, plastic wrap not fully covered the cheese which exposed it to air. -a metal bowl covered in plastic wrap contained what appeared to be a noodle meat cream sauce mixture. The bowl was unlabeled and undated. -a metal pot covered in foil but not sealed. Inside the pot appeared to be a type of soup. The pot was unlabeled, unsealed, and undated. -food wrapped in foil with hot dog like indentations. The foiled wrapped food was unlabeled and undated. -a glass bowl covered in foil with what appeared to be a white meat in sauce. The bowl was unlabeled and undated. -a bottle of thousand island dressing undated. -a bottle of French dressing undated.	N 452		

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N 452	Continued From page 17 -a bottle of Italian dressing undated. -a container of mayonnaise undated. According to the Wisconsin Food Code, the Federal Department of Agriculture's Food Code, and ServSafe standards, date marking is necessary to indicate when food must be consumed or discarded. These standards indicate refrigerated, read to eat (RTE), potentially hazardous food (PHF), and time/temperature controlled for safety (TCS) foods that are removed from manufacturer packaging and/or prepared for consumption must be date marked and discarded within 7 days. Refrigerated, RTE, PHF, and TCS foods prepared and packaged in a food processing plant shall also be date-marked when opened in the facility (date not to exceed 7 days). (ServSafe Coursebook, 7th Ed., 2017, p. 5-23) On 08/12/2024, at 3:00 PM, Surveyor interviewed Administrator M and Licensee B. Administrator M and Licensee B acknowledged the above concerns. Licensee B reported s/he labeled food when it arrived at the facility and not when food was opened. Administrator M and Licensee B reported they had stickers to indicate when food was bought and when food was opened. Administrator M and Licensee B reported they would utilize the stickers.	N 452		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area.	N 499		

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N 499	Continued From page 18	N 499		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 2 of 2 areas accessible to residents. Cleaning compounds and toxic substances were not securely stored in the dining room area and in the activity room area.

This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) YQT414, dated 09/01/2023, SOD YQT412, dated 10/21/2022, and SOD UXEE11, dated 01/16/2020.

Findings include:

The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 42 residents in client groups of physically disabled, advanced aged and irreversible dementia/Alzheimer's.

On 08/12/2024, at 8:40 AM, Surveyor toured the facility and observed the following:

On a shelf located near the dining room was a bottle of Zep all purpose cleaner.

The closet near the activity room contained a locking mechanism. The locking mechanism was not engaged, and the door was open. Inside the closet was a container of Member's Mark disinfecting wipes, two bottles of Clorox disinfecting mist, and a can of Lysol disinfecting spray.

On 08/12/2024 at 03:00 PM, Surveyors

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N 499	Continued From page 19 interviewed Administrator M. Administrator M confirmed toxic substances and cleaning compounds should be securely stored. Administrator M reported s/he will speak to staff.	N 499		
N 525	83.47(2)(d) Fire drills. 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 fire drills were conducted quarterly and at least one drill which simulated the conditions during usual sleeping hours for 1 of 2 years reviewed. There was not a fire drill conducted during the 3rd and 4th quarters of 2023, or a drill which simulated the conditions during sleeping hours in 2023. This deficiency is being cited for a third time. See	N 525		

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N 525	Continued From page 20 Statement of Deficiencies (SOD) YQT412, dated 10/21/2022, and SOD UXEE11, dated 01/16/2020. Findings include: On 08/12/2024, at 2:00 PM, Surveyors reviewed fire drills and identified the following: Two fire drills were conducted on 03/02/2023 and 06/01/2023. These fire drills did not simulate conditions during usual sleeping hours. There was no fire drill conducted in the 3rd and 4th quarters of 2023. There were 3 fire drills conducted in 2024 on 01/26/2024, 03/14/2024 and 04/10/2024. On 08/12/2024, at 3:00 PM, Surveyors interviewed Administrator M. Administrator M confirmed fire drills needed to be completed every quarter. Administrator M reported when the 3rd and 4th quarter fire drills were due to be completed, s/he had just taken over the position of administrator. Administrator M stated, "That's on me."	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding or other emergency or disaster drills were conducted semi-annually for 1 of 2 years. There were no other emergency or disaster drills conducted in	N 526		

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N 526	Continued From page 21 2023. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) YQT412, dated 10/21/2022, and SOD UXEE11, dated 01/16/2020. Findings include: On 08/12/2024, at 2:00 PM, Surveyors reviewed safety records and identified there was no evidence of tornado, flooding, or disaster drills in 2023. A tornado drill was conducted on 03/14/2024. On 08/12/2024, at 3:00 PM, Surveyors interviewed Administrator M regarding the emergency or disaster drills. Administrator M confirmed s/he was aware of the code requirement. Administrator M reported s/he was unaware if the other evacuation drills were completed. Administrator M reported s/he had just taken over the position about halfway through the year.	N 526		