STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017746	A. BUILDING: _____ B. WING _____	R-C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE OF OAK CREEK	1980 W RAWSON AVE OAK CREEK, WI 53154

(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 08/01/2024, Surveyord concluded a standard survey, a complaint investigation, and verification visit at Oak Park Place of Oak Creek for Statement of Deficiency (SOD) ZWH711 and 92LE12. Ten deficiencies were identified. Five were repeat deficiencies, one of the repeat deficiencies was cited for a third time in the following SODs: ZWH711, dated 08/23/2023, 0158 was a repeat deficiency 92LE12, dated 04/11/2023, 0243, 0389, and 0526 were repeat deficiencies. 8I4W11, dated 01/11/2022, 0499 and 0526 were repeat deficiencies. One complaint was substantiated. Under statutory provisions of WIS. State CH 50, a $200 revisit fee is assessed. Census: 60	{N 000}		
{N 158}	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of	{N 158}		

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

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{N 158}	Continued From page 1 misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not completely investigate the allegations of caregiver misappropriation for 1 of 1 resident. Resident 2's Power of Attorney (POA) K reported Resident 2 had two charges made to her/his credit card for Uber Eats. The provider did not complete the investigation regarding the misappropriation of Resident 2's credit card. This is a repeat deficiency. See Statement Of Deficiency (SOD) ZWH711, dated 08/23/2023. Findings include: On 02/07/2024, the Department received a complaint alleging a resident's credit card had been used by an employee. On 07/22/2024, at 7:00 AM, Surveyor reviewed the provider's self-report, dated 02/02/2024, which indicated the following: -On 02/01/2024 POA K informed Director of Housing (DOH) C two charges had been made to Resident 2's credit card around 12:30 AM on 02/01/2024. DOH C checked cameras and discovered a food delivery was made to the building at 2:00 AM and picked up by Caregiver L. Self-report indicated the internal investigation was ongoing.	{N 158}		

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{N 158}	Continued From page 2 On 07/22/2024, at 9:00 AM, Surveyors requested the investigation regarding the misappropriation of Resident 2's credit card. DOH C provided Surveyors with the department's self-report form and a list of questions. On 07/22/2024, at 2:30 PM, Surveyors requested the documentation for the completed investigation. On 07/23/2024, at 11:02 AM, DOH C emailed Surveyors an employee termination form for Caregiver L. The employee termination form, dated 02/14/2024, stated, "[Caregiver L] is currently under investigation [sic] for theft from a resident here at Oak Creek [s/he] has been terminated as I was informed that [police department] will be issuing a ticket to [her/him] and nothing [sic]." On 07/24/2024, at approximately 2:30 PM, Surveyors again requested the completed investigation regarding the misappropriation of Resident 2's credit card. As of 07/29/2024, at 3:30 PM, no documentation had been received. On 08/01/2024, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Regional Nurse (RN) J. DOH C reported s/he was the one who conducted the investigation. DOH C reported s/he interviewed both residents and staff and used the list of questions with the self-report form. DOH C reported the staff were to answer the questions and sign the document. DOH C reported s/he was unsure where s/he filed the investigation paperwork. DOH C reported s/he did not send a report to the department once the investigation was complete. DOH C stated, "I	{N 158}		

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{N 158}	Continued From page 3 knew it had to get done, there is no reason for it not to be done."	{N 158}		
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 ensure documentation was obtained from a registered nurse, physician, physician assistant, or clinical nurse practitioner indicating 5 of 6 employees reviewed were screened for communicable disease. Caregiver F's, Caregiver G's, Caregiver H's, Caregiver I's, and Caregiver J's communicable disease screening records were not signed by a registered nurse (RN) or physician. Findings include: On 07/22/2024, at 10:00 AM, Surveyors reviewed staff records and identified the following:	N 220		

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N 220	Continued From page 4 Caregiver F was hired on 08/09/2023. Caregiver F's record did not include a signature from a registered nurse, physician, physician assistant, or clinical nurse practitioner on her/his communicable disease screening. Caregiver G was hired 04/10/2024. Caregiver G's record did not include a signature from a registered nurse, physician, physician assistant, or clinical nurse practitioner on her/his communicable disease screening. Caregiver H was hired 03/27/2024. Caregiver H's record did not include a signature from a registered nurse, physician, physician assistant, or clinical nurse practitioner on her/his communicable disease screening. Caregiver I was hired on 03/13/2024. Caregiver I's record did not include a signature from a registered nurse, physician, physician assistant, or clinical nurse practitioner on her/his communicable disease screening. Caregiver J was hired on 11/11/2021. Caregiver J's record did not include a signature from a registered nurse, physician, physician assistant, or clinical nurse practitioner on her/his communicable disease screening. On 08/01/2024, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Regional Nurse (RN) J. RN J reported the facility nurse does the communicable disease screening in house. RN J reported at times an outside agency will complete them. RN J reported s/he was not aware Caregiver F's, Caregiver G's, Caregiver H's, Caregiver I's, and Caregiver J's communicable disease screenings were not signed by the person who reviewed them. DOH A	N 220		

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N 220	Continued From page 5 reported they were in the process of hiring a new facility nurse and had been without a nurse for some time.	N 220		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 6 employees obtained all department approved training as required. Caregiver G did not have training in fire	N 239		

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N 239	Continued From page 6 safety and first aid and choking within 90 days after starting employment. Findings include: On 07/22/2024, at approximately 10:30 AM, Surveyor reviewed employee files and identified the following: -Caregiver G was hired 04/10/2024. Caregiver G's record did not contain evidence of completed training in fire safety and first aid and choking or evidence of meeting an exemption in fire safety or first aid and choking. On 07/23/2024, Surveyors verified Caregiver G was not on the Community-Based Care and Treatment training registry for fire safety or first aid and choking. On 08/01/2024, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Regional Nurse (RN) J. DOH C reported Caregiver G was scheduled for class on 07/13/2024. DOH A reported due to illness s/he had to cancel the class. DOH C reported Caregiver G had recently completed the classes. DOH C reported s/he was aware the classes were to be completed in 90 days.	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	N 243		

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N 243	Continued From page 7 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 completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview the	N 243		

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N 243	Continued From page 8	N 243		

provider did not ensure 2 of 6 employees reviewed, obtained all training as required within 90 days after starting employment.

Caregiver F and Caregiver G did not have training in recognizing, preventing, managing, and responding to challenging behaviors within 90 days after starting employment.

Caregiver F did not have training in required client groups within 90 days after starting employment.

This is a repeat deficiency. See Statement Of Deficiency (SOD) 92LE12, dated 04/11/2023.

Findings include:

The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 90 residents advanced aged and irreversible dementia/Alzheimer's.

On 07/22/2024, at approximately 10:30 AM, Surveyors reviewed employee records and identified the following:

Recognizing, Preventing, Managing and Responding to Challenging Behaviors

Caregiver F was hired on 08/09/2023. Caregiver F's record did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training.

Caregiver G was hired on 04/10/2024. Caregiver G's record did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training.

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N 243	Continued From page 9 Client Group The facility was licensed to provide care and services to residents within the client groups of advanced aged and irreversible dementia/Alzheimer's. Caregiver F was hired on 08/09/2023. Caregiver F's record did not contain evidence of training or evidence of meeting an exemption for client group training. On 08/01/2024, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Regional Nurse (RN) J. When Surveyors inquired why Caregiver G and Caregiver F were missing trainings, DOH C and RN J were unsure.	N 243		
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:	N 386		

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N 386	Continued From page 10	N 386		

Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 2) had a comprehensive individual service plan (ISP) developed. Resident 2's ISP did not reflect Resident 2's assessed needs.

Findings include:

Record Review

On 07/22/2024, 2:00 PM, Surveyors reviewed Resident 2's record. Resident 2 was admitted on 01/19/2024, with diagnoses including dementia, hypertension, and chronic kidney disease. Resident 2's comprehensive assessment, undated, indicated Resident 2 self-administered her/his medications and required assistance with trash removal, bed making and laundry services. Resident 2's record did not contain evidence of an ISP. Resident 2's assessment indicated Resident 2 was independent in all other areas.

On 07/22/2024, at 2:30 PM, Surveyor requested Resident 2's ISP.

On 07/24/2024, at approximately 2:30 PM, Surveyor requested Resident 2's ISP.

On 08/01/2024, at 12:04 PM, Regional Nurse J emailed Resident 2's ISP. Surveyors reviewed Resident 2's ISP. Resident 2's ISP, undated, reported the following:

- "Focus - Resident requires housekeeping services (see schedule). Goal - Resident's bed will be made daily. Interventions - Make bed daily, removed resident's trash daily."

- "Focus - The resident is unable to self-administer the following medication(s): all.

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N 386	Continued From page 11 Goal - The resident will self-administer medication(s) safely and as prescribed. Interventions - Discuss current medications taken by the resident and have the resident demonstrate correct administration as required." Interview-Did they say anything about how they ensure current needs were added to the ISP or how they ensure they keep them up to date with current info? Did they confirm it was not comprehensive for the resident? Do you have an interview confirming what staff currently helped Resident 1 with? On 08/01/2024, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Regional Nurse (RN) J. DOH C reported s/he must have missed the request for Resident 2's ISP. RN J reported they could not find a signed copy of Resident 2's ISP but could send Surveyors the unsigned copy. RN J reported the facility nurse was responsible for completing resident ISPs. Summary Resident 2's ISP did not correctly identify Resident 2's needs and outcomes when it comes to medications and housekeeping services. Resident 2's ISP identified Resident 2 was unable to self-administer her/his medications and did not require assistance with laundry services. Resident 2's assessment identified Resident 2 self-administered all her/his medications and required assistance with laundry services.	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

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N 389	Continued From page 12	N 389		

Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 5 residents' (Resident 3 and Resident 4) Individual Service Plans (ISPs) were updated annually and signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and agreement with the resident's ISP. Resident 3's and Resident 4's ISPs were not signed by the resident or resident's legal representative for 2022 and 2023.

This is a repeat deficiency. See Statement Of Deficiency (SOD) 92LE12, dated 04/11/2023.

Findings include:

On 07/22/2024, at 11:00 AM, Surveyor reviewed resident files and identified the following:

-Resident 3 was admitted to the facility on 04/11/2020. Resident 3 was her/his own person. Resident 3's ISP, dated 07/18/2023, was not signed. Resident 3's record did not include an ISP

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N 389	Continued From page 13 for 2024. -Resident 4 was admitted to the facility on 07/31/2020. Resident 4's record indicated Resident 4 had a Power of Attorney (POA). Resident 4's ISP, dated 07/07/2022, was not signed. Resident 4's record did not include an ISP in 2023 or 2024. On 08/01/2024, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Regional Nurse (RN) J. RN J reported both the facility nurse and DOH C were responsible for ensuring the ISPs were updated annually and signed. RN J reported they were implementing a process of keeping a hard copy and wanting to keep a copy in the computer system. DOH C and RN J were unsure of where the 2023 signed ISPs were.	N 389		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored	N 406		

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	0017746	A. BUILDING: _____ B. WING _____	R-C 08/01/2024

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OAK PARK PLACE OF OAK CREEK	1980 W RAWSON AVE OAK CREEK, WI 53154

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N 406	Continued From page 14 in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not establish an effective procedure for proper destruction and disposal of expired medications. Expired medications were observed stored with resident's non-expired medications in 2 of 2 medication carts. Findings include: On 07/24/2024, at 01:56 PM, Surveyors observed the medication carts. Surveyors observed the following expired medications: First Floor Medication Cart: Resident 5 Ondansetron hydrochloride (HCL) 4 milligrams (MG) expired 12/8/2023 Calcium antacid 500 MG chew expired 02/22/2024 Resident 6 Ibuprofen tab 800 MG expired 5/15/2024 Benzonatate 100 MG capsule expired 05/30/2024 Acetaminophen 325 MG tablet expired 05/30/2024 Benzonatate capsule 100 MG expired 05/16/2024 Memory Care Medication Cart:	N 406		

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N 406	Continued From page 15 Resident 7 Acetaminophen 325 MG tablet expired 08/29/2023 Acetaminophen 325 MG tablet expired 09/12/2023 Acetaminophen 325 MG tablet expired 08/29/2023 Resident 8 Docusate sodium 100 MG soft gel expired 06/04/2023 Cyclobenzaprine 5 MG tablet expired 03/01/2024 Acetaminophen 325 MG tablet expired 03/02/2024 Resident 9 Acetaminophen 325 MG tablet expired 01/23/2024 Resident 10 Loperamide 2 MG capsule expired 01/04/2024 On 7/24/2024, at 2:30 PM, Surveyors interviewed Director of Housing (DOH) C. DOH C reported staff were responsible for auditing the medication carts weekly. DOH C reported staff brought the expired medications to the nurses and the nurses were responsible for destroying the medications. On 08/01/2024, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Regional Nurse (RN) J. RN J reported all expired medications were out of the medication carts. RN J reported the pharmacy came in to do an audit of the medication rooms.	N 406		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that	N 499		

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N 499	Continued From page 16 cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. 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 3 of 3 locations observed. Cleaning compounds were stored in the activity room, spa rooms, and dining room. This is a repeat deficiency. See Statement of Deficiency (SOD) 8I4W11, dated 01/11/2022. Findings include: On 07/24/2024, at 1:00 PM, Surveyors toured the facility and observed the following: - In the northside spa room located on the first floor, there was an unsecured container of Sani-Cloth Germicidal disposable wipe. - The spa room located in the center of the building on the first floor had an unsecured bottle of Clorox Fuzion cleaner disinfectant. Also inside the spa room was a housekeeping cart which contained two bottles of Clorox toilet bowl cleaner, Clorox Fuzion cleaner disinfectant, and Sani-Cloth bleach wipes. The housekeeping cart contained a locking mechanism. The locking mechanism was not engaged. - The first-floor activity room underneath the kitchen sink was a bottle of Palmolive dish detergent, two containers of Sani-Cloth germicidal disposable wipes, Comet with Bleach, and Powerhouse glass cleaner. The cupboard	N 499		

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N 499	Continued From page 17 doors did not contain a locking mechanism. - The memory care activity room underneath the kitchen sink was a bottle of Awesome window cleaner, Awesome window concentrate, Dawn dish detergent, two bottles of Provon Antimicrobial Foam, and Comet with bleach. - The memory care dining room in the lower cabinet was a container of PDI Sani- Cloth germicidal wipes. Surveyor observed residents moving freely throughout the facility during the survey. On 07/24/2024 at 2:30 PM, Surveyors interviewed Director of Housing (DOH) C. DOH C confirmed all toxic substances were to be securely stored. DOH C reported s/he would provide training to staff to ensure all chemicals were locked up.	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	N 525		

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N 525	Continued From page 18 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 simulated the conditions during usual sleeping hours for 2 of 2 years reviewed. There was not a fire drill conducted in the second and third quarters of 2023, or a drill which simulated the conditions during sleeping hours in 2022 and 2023. Findings include: On 07/22/2024, at approximately 11:30 AM, Surveyors reviewed facility fire drills and identified the following: Four fire drills were conducted on 01/13/2022, 04/21/2022, 07/21/2022 and 10/24/2022. These fire drills did not simulate conditions during usual sleeping hours. Two fire drills were conducted on 01/27/2023 and 11/06/2023. Surveyors did not locate documentation which indicated fire drills were completed in the second and third quarters in 2023. On 07/24/2024, at 2:30 PM, Surveyors interviewed Director of Housing (DOH) C. DOH C confirmed fire drills needed to be completed every quarter. DOH C reported s/he completed a fire drill during the first quarter of 2023 but was unsure where the documentation was. DOH C reported s/he had completed a 3rd shift drill but was unsure of when the 3rd shift drill was	N 525		

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N 525	Continued From page 19 completed. DOH C reported s/he would ensure a better system for the files and batching the files to ensure documentation was not lost.	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 at least semi-annually for 1 of 1 year. There were no other drills conducted in 2023. This deficiency is being cited for a third time. See Statement Of Deficiency (SOD) 92LE12, dated 04/11/2023, and SOD 8I4W11, dated 01/11/2022. Finding include: On 07/22/2024, at approximately 11:30 AM, Surveyors reviewed safety records. Surveyors did not locate any documentation indicating other emergency and disaster drills were conducted in 2023. On 08/01/2024, at 11:30 AM, Surveyors interviewed Director of Housing (DOH) C and Regional Nurse (RN) J. RN J reported the Director of Maintenance and DOH C were responsible for ensuring the other drills were complete. RN J reported s/he was unsure why the drills were not completed.	N 526		