Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7117	A. BUILDING: _____ B. WING _____	R-C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA ALBUQUERQUE	1620 INDIAN SCHOOL ROAD NE ALBUQUERQUE, NM 87102

(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
{A 000}	Initial Comments The following deficiencies were cited during an onsite Revisit/Follow-up survey completed on [redacted]23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults. Resident Census: 140 ABBREVIATIONS: Medication Administration Record: MAR Milligrams: mg Milliliter: ml Enteric-Coated: EC Delayed Release: DR Film-Coated: F/C Extended-Release: ER Procedural Reaction Time: PRT Hydrochloride: HCL Memory Care Director: MCD Memory Care Unit: MCU	{A 000}		
{A 019}	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of	{A 019}	A 019 7 NMAC 8.2.19 Staffing Ratios 1.Staffing ratio requirements of at least 1 direct care staff member on duty per every 15 residents will be monitored by Facility Administrator. 2. Facility increased staff in AL to 9 DCS during waking hours and 5 DCS staff during sleeping hours on [redacted]/2023. 3. Facility Administrator will monitor that all call pendants will be responded to within 15 minutes or less of the pendant being pressed by running and reviewing daily pendant report. 4. Facility Health & Wellness Director will provide a retraining on the response times for pendants being pressed with Direct Care Staff on1[redacted]023. Record of this retraining will be kept in Direct Care Staffs personal file. New direct care staff members will receive this training on pendant response time upon hire. 5. Health & Wellness director will ensure ongoing compliance is met by reviewing weekly schedules.	[redacted]2023

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mia Shaver — TITLE: Executive Director. — (X6) DATE: 10/20/2023

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{A 019}	Continued From page 1 the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from survey dated ([redacted]22. 7.8.2.19 A (1, 5) Based on record review and interview, the facility failed to ensure that there was enough Direct Care Staff (DCS) on duty at all times to provide the basic care, resident assistance, and the required supervision based on the assessment of the residents' needs.	{A 019}		

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{A 019}	Continued From page 2 This deficient practice could likely negativity effect the safety and welfare of the [redacted] residents identified on the resident census provided by the Executive Director on [redacted]/23, to be at risk of harm, injury if there are not adequate staffing available to assist residents. The findings are: Findings related to required staffing: A. Record review of the Facility Census for the Assisted Living (AL) portion of the facility on [redacted]/23 revealed there were 124 residents which would require: 1. Nine (9) DCS on duty and awake at all times during resident waking hours. 2. Three (3) DCS on duty and awake at all times and two (2) DCS immediately available on the premises during sleeping hours. B. Record review of the Staff Schedule for [redacted]/23 through [redacted]23 for the AL portion of the facility revealed: 1. On [redacted]/23 there were only: a. Six (6) DCS scheduled from 6:00 am to 6:00 pm. b. Four (4) DCS scheduled from 10:00 pm to 6:00 am. 2. On [redacted]/23 there were only six (6) DCS scheduled from 6:00 am to 6:00 pm. 3. On [redacted]/23 there were only: a. Six (6) DCS scheduled from 6:00 am to 6:00 pm. b. Four (4) DCS scheduled from 6:00 pm to 10:00 pm c. Three (3) DCS scheduled from 10:00 pm to 6:00 am. 4. On [redacted]23 there were only:	{A 019}		

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{A 019}	Continued From page 3 a. Seven (7) DCS scheduled from 6:00 am to 10:00 am. b. Six (6) DCS scheduled from 10:00 am to 11:00 am. c. Five (5) DCS scheduled from 11:00 am to 6:00 pm. 5. On [redacted]23 there were only seven (7) DCS scheduled from 6:00 am to 6:00 pm. C. On [redacted]/23 at 10:54 am, during an interview, DCS #5 confirmed that there are usually four (4) to six (6) staff on each shift and feels that the facility needs to hire more staff for each shift. D. Record review of the facility's pendant reports for [redacted]/23 through [redacted]/23, revealed: 1. On [redacted]R #7's pendant was pressed at 4:26 pm, with a response time of 28 minutes and was pushed for assistance six (6) times. 2. On [redacted]23 R #14's pendant was pressed at 3:31 pm, with a response time of 30 minutes and was pushed for assistance seven (7) times. 3. On [redacted]/23 R #7's pendant was pressed at 1:31 pm, with a response time of 31 minutes and was pushed for assistance seven (7) times. 4. On [redacted]3 R #18's pendant was pressed at 11:19 am, with a response time of 51 minutes and was pushed for assistance eleven (11) times, and again at 1:25 pm, with a response time of 50 minutes and was pushed for assistance eleven (11) times. E. Record review of the facility's Policy on Pendant Response times, it revealed that the expected response time for DCS to respond when resident's push their call pendant for DCS assistance is within approximately 10 minutes. F. On [redacted]23 at 2:30 pm, during an interview, R #7 confirmed that the response time when [redacted]	{A 019}		

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{A 019}	Continued From page 4 uses [redacted] pendant is "shaky" (inconsistent) and there have been times where [redacted] was on the floor waiting for staff to help [redacted] up after a fall (could not recall an exact date). G. On [redacted] 23 at 2:40 pm, during an interview R #13 confirmed that there are times where it takes DCS a while (slow) to respond to [redacted] pendant call because they are helping with other residents, and it takes longer around lunch time because that is the busiest time and DCS are helping other residents to and from the dining room. H. On [redacted] 23 at 1:50 pm, during an interview, the Executive Director confirmed that based on the number of current residents in the AL, there were not enough DCS scheduled to meet required staffing ratio for [redacted] 23 through [redacted] 23 and that the time responses on the pendant reports were longer than their required response times.	{A 019}		
{A 032}	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and	{A 032}	A 032 7 NMAC 8.2.32 Reporting of Incidents 1. Director of Health and Wellness or Memory Care Director will report all reportable incidents of suspected abuse, neglect or exploitation in the required 24 hour time frame in accordance with 7.1.13 NMAC and submit form Health Facility incident report (SFY 2017) to license authority. 2. Director of Health and Wellness or Memory Care Director will complete required Complaint Narrative Investigation Report(5 day follow up) following all reported incidents in accordance with 7.1.13 NMAC and submit to license authority. 3. Facility will conduct an internal investigation on all reportable incidents. 4. Facility Administrator, Director of Health and Wellness, Assistant Health and Wellness Director and Memory Care Director will watch Incident Management Training Video provided by the NM Health Care Association and test congruent to training. To be completed by [redacted] 023.	[redacted] /2023

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{A 032}	Continued From page 5 documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from a survey dated [redacted]/22. Deficiencies will be cited: See complaint survey [redacted]	{A 032}	5. Record of these completed trainings will be kept in Directors personal file. 6. Facility Administrator will monitor all Incident reporting to ensure compliance is met monthly.	
{A 033}	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal	{A 033}	A 033 7 NMAC 8.2.33 Resident Rights 1.Facility Administrator will monitor for compliance that an Assessment and ISP will be completed upon admission by facility Administrator or Director of Health and Wellness. Assessment and ISP will be updated as needed for changes to residents care needs or every six months. ISP to detail any special care needs that a resident shall need including additional care checks. Residents health care provider shall provide a physician report to include all health care needs resident will need so that can be reflected in the residents assessment and ISP.	[redacted]/2023

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{A 033}	Continued From page 6 rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits	{A 033}	2. Facility Adminsitraor will do a monthly audit on all residents ISP to ensure that they have been completed and updated in a timely manner.	

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{A 033}	Continued From page 7 with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist	{A 033}		

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{A 033}	Continued From page 8 and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from a survey dated [redacted]22. Deficiencies will be cited: See complaint survey [redacted]	{A 033}		
{A 035}	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and	{A 035}	A 035 7 NMAC 8.2.35 Medication 1.Facility Health and Wellness Director and Memory Care Director will audit all MARS to ensure that medication aides are assisting with medication at the appropriate times and in the proper manner.	[redacted]2023

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{A 035}	Continued From page 9 federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ),	{A 035}	2. Facility Maintenance Director will install a key box outside of the Memory Care unit to hold extra keys in the event someone needs to enter the memory care. 3. All Direct Care Staff will be retrained by Health and Wellness Director on proper procedures for any missed medications, notifications to primary doctors and incident reporting.. Training will be documented and kept in Direct care staff personal file [redacted]3. 4. Health & Wellness director will do a monthly MAR audit to ensure that all medication was dispensed and assisted with in a timely manner.	

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{A 035}	Continued From page 10 intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other);	{A 035}		

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{A 035}	Continued From page 11 (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and	{A 035}		

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	7117	A. BUILDING: _____ B. WING _____	R-C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA ALBUQUERQUE	1620 INDIAN SCHOOL ROAD NE ALBUQUERQUE, NM 87102

(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
{A 035}	Continued From page 12 (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This an uncorrected deficiency from a survey dated [redacted]22 7.8.2.35 Based on record review and interview, the facility failed to ensure for [redacted] esidents whose Medication Administration Record (MAR) were reviewed for compliance that all medications listed on the MAR were being given to the resident. This deficient practice could likely result in residents being at risk of harm or illness, if medications are not given as ordered by the physician and adverse reactions or health complications occur. The findings are: A. Record review of a physician's order dated [redacted]23 revealed R #2 was to receive one	{A 035}		

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MORADA ALBUQUERQUE	1620 INDIAN SCHOOL ROAD NE ALBUQUERQUE, NM 87102

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{A 035}	Continued From page 13 [redacted] every 6 hours. B. Record review of R #2's August [redacted] MAR revealed: 1. On [redacted]23, for the 12:00 am dose, the resident did not receive [redacted] 2. The exception noted on MAR revealed an entry by Direct Care Staff (DCS) #12 for the 12:00 am dose of [redacted] on [redacted]23 and stated the DCS, "Forgot to give med." 3. On [redacted]/23, for the 12:00 am dose, the resident did not receive [redacted] 4. The exception noted on the MAR revealed an entry by DCS #13 for the 12:00 am dose of [redacted]/23 and stated, "Medication not given there was no entry card to get into the MC (Memory Care) by the caretakers near elevator C and I didn't have my card to enter from the Southside entrance. Will not be going through that route especially at midnight." C. On [redacted]/23 at 1:27 pm, during an interview, the MCD confirmed the R #2 did not receive following medications: 1. On [redacted]23, the resident did not receive [redacted] 12:00 am dose of [redacted] 2. The exception noted on the MAR revealed, an entry by DCS #12 for the 12:00 am dose of [redacted]/23 and stated, "Forgot to give med." 3. On [redacted]/23, the resident did not receive her 12:00 am dose of [redacted] 4. The exception noted on the MAR revealed an	{A 035}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA ALBUQUERQUE	1620 INDIAN SCHOOL ROAD NE ALBUQUERQUE, NM 87102

(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
{A 035}	Continued From page 14 entry by DCS #13 for the 12:00 am dose of [redacted]/23 and stated, "Medication not given there was no entry card to get into the MC (Memory Care) by the caretakers near elevator C and I didn't have my card to enter from the Southside entrance. Will not be going through that route especially at midnight." 5. The MCD stated she was not sure why DCS #12 forgot to give R #2[redacted]23 for the 12:00 am dose. 6. The MCD stated DCS #13 still should have been able to get into the MCU, because there were staff there on shift, and all they had to do was knock or ring the doorbell.	{A 035}		
{A 065}	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC,	{A 065}	1.Facility's Maintenance Director will conduct monthly fire and safety evacuation drills with all staff, rotating through each shift. Residents will be encouraged to participate in fire drills and practice evacuations will take place according to floors. Record of all Fire Drills will be kept in Maintenance Directors office in Fire Safety and Evacuation Binder. A log will be kept of each active participants name, the day of and time of fire drill, a head count of participants and the start and end time of the drill. 2. Facility Admisitraor will review all Fire drills monthly to ensure compliance is met.	[redacted]/2023

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{A 065}	Continued From page 15 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from survey dated [redacted]22. 7.8.3.65 B (2, 3,5) Based on record review and interview the facility failed to ensure that the monthly fire drill records included the following required information: 1. The time of drill. 2. The number of staff who participated in the drill. 3. Evacuation time in total minutes. These deficient practices could likely result in the [redacted] residents identified on the resident census provided by the Executive Director on [redacted]/23, to be at risk of harm, injury, or death if a fire or other emergency that required evacuation and: 1. There is no documentation of what time of day the drills were completed to ensure that staff on all shifts participate in the drills. 2. Staff do not know how long it will take to evacuate the residents from the facility. 3. If there are staff who do not know how to safely evacuate the residents, because the facility is not tracking how many staff have participated in each monthly drill. The findings are: A. Record review of the facility's Fire Drill Reports dated [redacted]/23 through [redacted]23, revealed there was no documentation of the following required	{A 065}		

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{A 065}	Continued From page 16 information: 1. Fire drill dated [redacted]/23 at 11:00 am: a. The number of staff who participated in the drill. b. Evacuation time in total minutes. 2. Fire drill dated [redacted]23: a. The time of the drill. b. The number of staff who participated in the drill. c. Evacuation time in minutes (noted: "not due for annual" - No evacuation completed"). 3. Fire drill dated [redacted]/23 at 3:00 am: a. The number of staff who participated in the drill. b. The evacuation time in minutes (noted: "not time for overnight evacuation" - No evacuation completed). 4. Fire drill dated [redacted]/23 at 8:00 am: a. The number of staff who participated in the drill. b. The evacuation time in minutes (noted: "not time for evacuation drill" - No evacuation completed"). B. On [redacted]/23 at 1:52 pm, during an interview, the Executive Director confirmed the above findings related to the missing required information on the facility's Fire Drill Reports dated [redacted]/23 through [redacted]/23.	{A 065}		