

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151329	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/11/2013
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NAME OF PROVIDER OR SUPPLIER MARGARET MARY COMMUNITY HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 321 MITCHELL AVE BATESVILLE, IN 47006
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 004718</p> <p>Survey Date: 9-9/11-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 09/16/13</p>	S000000		
S000266	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(4)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(4) Review the bylaws at least triennially.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S000270	<p>Based on review of documents and interview, the governing board failed to review their bylaws at least triennially.</p> <p>Findings:</p> <p>1. Review of the governing board by-laws indicated they were last reviewed 9-28-09.</p> <p>2. In interview, on 9-9-13 at 12:55 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p>	S000266	<p>1. The governing board bylaws will be presented to the Margaret Mary Health Board of Directors for review and approval. Supporting documentation is attached. 2. The review and approval of the governing board bylaws have been added to Executive Secretary to President's calendar for triennial review. 3. Margaret Mary Health's President will assure the governing board bylaws will be reviewed triennially at a minimum in the future. 4. This deficiency was correct on September 23, 2013.</p>	09/23/2013	
	<p>Based on document review and interview, the governing board failed to review reports of quality activities for 6 directly-provided services and 1</p>	S000270	<p>1. The Hospital Performance Improvement Plan was revised to include monitors and reporting for CT scanner, MRI scanner, EMG, Massage Therapy, Nuclear Medicine, and Ultrasound, and</p>	09/23/2013	

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	<p>contracted service.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the directly-provided services of CT (computerized tomography) Scanner, MRI (Magnetic Resonance Imaging) scanner, Electromyography (EMG), Massage Therapy, Nuclear Medicine, and Ultrasound. Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the contracted bioengineering service. In interview, on 9-11-13 at 4:30 pm, employee #A3 confirmed the above and no further documentation was provided prior to exit. 		<p>Bioengineering Service. All monitors will be reported through the established hospital-wide system to include Medical Staff and Board of Directors. Supporting documentation is attached.</p> <ol style="list-style-type: none"> A review of the "Hospital Document Request - QAPI Monitor" list provided by the ISDH Surveyors at the time of survey was conducted on September 20, 2013 to assure all applicable services including CT scanner, MRI scanner, EMG, Massage Therapy, Nuclear Medicine, and Ultrasound, and Bioengineering Service is part of the hospital's QAPI program. The respective Department Managers will be responsible for tracking data and Quality Services Director will be responsible for submitting to Medical Staff and Board of Directors. The deficiency was corrected on September 23, 2013. 		

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include monitors and standards for 6 services directly-provided by the hospital as part of its comprehensive quality assessment and performance improvement (QAPI) program and failed to have ongoing activities for one of its directly-provided services as part of its QAPI program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the directly-provided services of CT (computerized tomography) Scanner, MRI (Magnetic Resonance Imaging) scanner, Electromyography (EMG), Massage Therapy, Nuclear Medicine,</p>	S000406	<p>1. The Hospital Performance Improvement Plan was revised to include monitors and reporting for CT scanner, MRI scanner, EMG, Massage Therapy, Nuclear Medicine, and Ultrasound, and Plant Operation services. All monitors will be reported through the established hospital-wide system to include Medical Staff and Board of Directors. Supporting documentation is attached. 2. A review of the "Hospital Document Request - QAPI Monitor" list provided by ISDH State Surveyors at the time of survey was conducted on September 20, 2013 to assure all applicable services including CT scanner, MRI scanner, EMG, Massage Therapy, Nuclear Medicine, and Ultrasound, and Plant Operation services, is part of the hospital's QAPI program. 3. The respective</p>	09/23/2013			

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S000554	<p>and Ultrasound.</p> <p>2. In interview, on 9-11-13 at 4:30 pm, employee #A3 confirmed the above and no further documentation was provided prior to exit.</p> <p>3. Review of the facility's QAPI program indicated it did not include ongoing outcomes of the Plant Operations service for the months of August through December, 2012.</p> <p>4. In interview, on 9-11-13 at 3:30 pm, employee #A3 confirmed there were no reports of outcomes of the Plant Operations service for the months of August through December, 2012. The employee also indicated the department had decided to change to a new monitor and standard at that time but there were no reports of outcomes of the new monitor. No further documentation was provided by exit.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, the hospital</p>	S000554	<p>Department Managers will be responsible for tracking data and Quality Services Director will be responsible for submitting to Medical Staff and Board of Directors. 4. The deficiency was corrected on September 23, 2013.</p> <p>1. The toilet paper and hand</p>	09/27/2013	

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	<p>created a condition which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors in 3 instances.</p> <p>Findings:</p> <p>1. On 9-9-13 at 1:25 pm, in the presence of employees #A1, #A4, and #A5, it was observed in the housekeeping storage area, there were 39 packages of handtowels stored on an open shelf. The ends of the packages were not protected by a wrapper or any other means and the shelves were uncovered. It was also observed there were pipes above the shelves which had a great deal of dust.</p> <p>2. On 9-9-13 at 2:25 pm, in the presence of employees #A1, #A4, and #A5, it was observed in a housekeeping closet in the Radiology area, there were 2 rolls of toilet paper completely unprotected by a wrapper or any other means stored on an open shelf. It was also observed there were 7 rolls of handtowels stored on the open shelf. The handtowels were not protected by a wrapper or any other means.</p> <p>3. On 9-10-13 at 10:10 am, in the presence of employees #A1, #A4, and</p>		<p>towels that were stored in the housekeeping storage area were placed in a box while not exposing the ends. The pipes in the housekeeping storage area were cleaned. The floor scrubbing machine and battery charger were relocated to the first floor housekeeping closet. 2. A housekeeping staff meeting was held on September 27, 2013 and the following items were discussed: the proper storage of toilet paper and hand towels, cleaning of pipes in the housekeeping storage area, and the proper storage of floor scrubbing machine and battery charger. 3. The Housekeeping Supervisor will be responsible for proper storage of toilet paper and hand towels, cleaning of pipes in the housekeeping storage area, and the proper storage of floor scrubbing machine and battery charger. 4. The deficiencies were corrected on September 27, 2013.</p>		

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	<p>#A5, it was observed in a housekeeping supply closet in the offsite Hansen Center, there 7 packages of handtowels stored on the open shelf. The handtowels were not protected by a wrapper or any other means. It was also observed there were 5 large rolls of handtowels stored on the open shelf. The handtowels were not protected by a wrapper or any other means.</p> <p>4. In all the above situations, the lack of protection of the packages of products used patients, employees and visitors, posed the potential for cross-contamination.</p> <p>5. On 9-9-13 at 1:40 pm, in the presence of employees #A1, #A4, and #A5, it was observed in a biohazardous waste storage room there was a large floor scrubbing machine being recharged. Recharging the machine in this area posed the potential for cross-contamination.</p>			

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S000612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling. Based on observation and document review, the hospital failed to follow its policy for the storage of linen in 1 instance.</p> <p>Findings:</p> <p>1. On 9-10-13 at 10:15 am, in the presence of employees #A1, #A4, and #A5, it was observed in a linen storage closet in the Hansen offsite facility, there were 4 open shelves, each containing linen. The linen on the shelving was also observed to be uncovered.</p> <p>2. Review of a facility document entitle PATIENT CARE - INFECTION CONTROL, TITLE: LINEN</p>	S000612	<p>1. The linens stored in the Hansen offsite facility in the linen storage closet were covered. 2. A housekeeping staff meeting was held on September 27, 2013, and the proper storage of the linens at the Hansen offsite facility was discussed. 3. The Housekeeping Supervisor will be responsible for proper storage of linens at the Hansen offsite facility. 4. Deficiencies were corrected on September 27, 2013.</p>	09/27/2013			

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S000868	<p>HANDLING, approved 2-8-12, indicated clean linen is stored in the clean storage room in a closed cart or covered shelving until used.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed:</p> <p>(i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff;</p> <p>(ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or</p> <p>(iii) within forty-eight (48) hours after an admission.</p> <p>Based on document review and interview, the medical staff failed to ensure that each patient admitted to the facility that had a history & physical examination performed prior to admission had changes noted in the medical record (MR) on admission for 2 of 2 obstetrical MRs reviewed (Patient #10 & 11).</p>	S000868	<p>1. A memo was sent to Margaret Mary Health's Obstetrics Physicians reminding physicians that all OB patients shall have a prenatal record including physical examination and evidence of prenatal clinical and diagnostic studies. This can also serve as the pre-op history and physical examination provided the examination was completed no more than 30 days prior to</p>	09/25/2013			

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	<p>Findings include:</p> <p>1. Review of policy/procedure History & Physical indicated the following: "2. If a complete history has been recorded and a physical exam performed within (30) days prior to the patient's admission to the hospital, a reasonably durable, legible copy may be used in the patient's hospital medical record in lieu of the admission history and physical. An interval admission note that includes all additions to the history and any subsequent changes in the physical examination must be recorded within twenty-four (24) hours of admission. 8. All OB patients shall have a prenatal record including physical examination and evidence of prenatal clinical and diagnostic studies. This can also serve as the pre-op history and physical examination provided the examination was completed no more than thirty (30) days prior to admission. If the office record is used, it should be updated to the time of delivery." This policy/procedure was last reviewed/revised on 07-09.</p> <p>2. Review of patient #10's MR indicated the patient was admitted to the facility on 07-30-13 and the MR indicated the prenatal record without an update was in the MR.</p>		<p>admission. If the office record is used, it should be updated to the time of delivery. 2. OB will review documentation on OB admissions to assure prenatal records are updated to the time of delivery. 3. The OB Manager will be responsible for documentation review of prenatal record updates to the time of delivery. 4. Deficiencies were corrected on September 25, 2013.</p>		

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S000952	<p>3. Review of patient #11's MR indicated the patient was admitted to the facility on 04-22-13 and the MR indicated the prenatal record without an update was in the MR.</p> <p>4. On 09-11-13 at 1440 hours staff #42 confirmed that physicians do not update prenatal records when patients are admitted to the facility.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to follow approved medical staff policies/procedures for 4 of 7 transfusions reviewed.</p> <p>Findings include: 1. On 9/10/13 between 1:30 p.m. and 3:30 p.m. review of policy/procedure titled: "Patient Care- Medications,</p>	S000952	<p>1. The medication policy called "blood transfusion" was reviewed with the Medical surgical and Special care RN staff reminding the nurses to obtain vital signs prior to a blood transfusion, that should occur within 30 minutes prior to the start of the transfusion. The blood transfusion must also be started within 30 minutes after it is obtained from the Blood Bank. A review that vital signs must be</p>	09/12/2013	

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	<p>Blood Transfusion, Effective March 2013," revealed: " PRE-PROCEDURE 10. Obtain vital signs.....prior to the transfusion.....This should occur within 30 minutes prior to the transfusion. PROCEDURE 14. Blood transfusion must be started within 30 minutes after it is obtained from the Blood Bank. 6. Ensure vital signs are taken at intervals indicated in the EMR (Electronic Medical Record).....Appropriate intervals for vital signs from start of blood include; 5 minutes, 15 minutes, 1 hour, 2 hours, 3 hours, and 4 hours."</p> <p>2. Review of seven transfusion records on 9/10/13 between 1:30 p.m. and 3:30 p.m. revealed :</p> <p>a. Transfusion #1 had the blood released from the blood bank at 02:43 after the start of the transfusion at 21:58, the previtals at 22:17 were taken after the start of the transfusion at 21:58, and the 5 minute vitals at 22:22 were taken 24 minutes after the start of the transfusion at 21:58.</p> <p>b. Transfusion #2 had the previtals taken at 11:58 which is 52 minutes before the start of the transfusion at 12:50 when the policy/procedure calls for within 30 minutes of the start of the transfusion.</p> <p>c. Transfusion #4 had the previtals taken at 11:00 which is the same as the</p>		<p>taken at intervals indicated which include: 5 minutes, 15 minutes, 1 hour, 2 hours, 3 hours, and 4 hours. The review included the need to obtain a consent for blood transfusion prior to the administration of the blood product. Supporting documentation attached. 2. A blood transfusion documentation audit will be conducted on a monthly basis beginning on October 1 2013. The audit will include the following : a. Vitals signs are documented prior to a blood transfusion, but within 30 mins prior to the start of the transfusion. b. Blood transfusions are started within 30 minutes after leaving the blood bank . c. Vital signs are documented at intervals of 5 mins, 15mins, 1 hour, 2 hours, 3 hours, and 4 hours. d. Consents are obtained prior to the administration of the blood product. 3. The Medical surgical manager will be responsible to assure the blood transfusion policy is followed for all blood transfusions on the Medical Surgical unit and in the Special Care Unit. 4. An email reminder was sent to the Medical Surgical and Special Care nursing staff on September 12, 2013. A staff meeting will be held in October 2013 to review the email reminder for all Medical surgical and special care nursing staff.</p>				

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S001168	<p>start of the transfusion at 11:00.</p> <p>d. Transfusion #5 was released from the blood bank at 15:02 which is after the start time of 12:25 and the completion time of the transfusion is at 15:03 one minute after the time of release from the blood bank.</p> <p>e. Two transfusions were found to have incomplete consent forms, transfusions #1 and #5.</p> <p>3. In interview on 9/10/13 between 1:30 p.m. and 3:30 p.m. staff person #1 acknowledged the above information was in the EMR and that transfusion records were not being reviewed for inconsistent information.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the hospital failed to document properly keeping a discharge log least in accordance with manufacturer's recommendations for 1 of 1 defibrillator.</p>	S001168	<p>1. The daily crash cart/defibrillator check form and policy titled "Crash Cart & Defibrillator Check" were revised based on the manufacturers guidelines to indicate evidence that a shift/system check is performed every shift to verify</p>	09/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151329		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/11/2013	
NAME OF PROVIDER OR SUPPLIER MARGARET MARY COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 321 MITCHELL AVE BATESVILLE, IN 47006			
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	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the M4735A HeartStart XL /Defibrillator/Monitor manual indicated the manufacturer indicated to perform a "Shift/System Check" every shift to verify that the HeartStart XL is functioning properly and to ensure that necessary supplies and accessories are present and ready for use. 2. Further review of the manual indicated when using external paddles, in addition to the machine conducting a self-check, a list of other checks to be done, including Defibrillator Inspection, Cables/Connectors, Paddles/Pads, Monitoring Electrodes, Charged Batteries, AC Power Cord, Printed Paper, Data Card, Ancillary Supplies, and SpO2 Sensor. The manual illustrated these checks as being printed on the test strip. The personnel who were conducting the test could then indicate they completed the necessary checks. 3. Review of a document entitled Daily Crash Cart/Defibrillator Check, indicated it included a column entitled Defib check. 4. Review of a document entitled Crash 		<p>that the defibrillator is functioning properly and to ensure that necessary supplies and accessories are present and ready for use. When using external paddles, in addition to the machine conducting a self check, a list of other checks to be done, including defibrillator inspection, cables/connectors, paddles/pads, monitoring, electrodes, charged batteries, ac power cord, printed paper, data card, ancillary supplies, and spo2 sensor. 2. A memo was sent to the clinical staff advising them of the revision to the Daily Crash Cart/Defibrillator Check Form (which includes verification that all items on system check report have been completed) and policy titled "Crash Cart & Defibrillator Check" on September 27, 2013. Inservices will be held during the month of October 2013 to review the changes to the Daily Crash Cart/Defibrillator Check Form and the policy titled "Crash Cart & Defibrillator Check" for all involved clinical staff. 3. The clinical managers and the Code Blue team members will assure that the daily crash cart/defibrillator checks are conducted as per the policy and manufactures recommendations. 4. These deficiencies were corrected on September 27, 2013.</p>				

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	<p>Cart & Defibrillator Check, approved 2-8-12, indicated the following:</p> <p>During operational hours or once a shift, every crash cart will be checked by a qualified individual as per manufacturer's recommendation and verify ... the defibrillator is functioning properly. The qualified individual will ... perform the shift/system check [and] print the system check report.</p> <p>5. Review of the document entitled Crash Cart & Defibrillator Check indicated it did not define the column entitled Defib check.</p> <p>6. In interview, on 9-9-13 at 3:10 pm, hospital staff, when asked if they retained a copy of the printed test strip, indicated they did not.</p> <p>7. Due to lack of documentation, lack of retention of the printed test strip, and no definition of Defib check, it could not be determined if the staff conducting the test each shift were complying with the manufacturer's recommendation for performing a "Shift/System Check".</p>				

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S001186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy in 1 instance.</p> <p>Findings:</p> <p>1. Review of a document entitled Environment of Care Fire Safety Management Plan, Page 4 of 7, Effective Date June 2012, indicated fire drills will be held in hospital occupancies once per shift, per quarter.</p>	S001186	<p>1. A review of the Fire Safety Management Plan was conducted with the Safety Officer and Plant Operations Manager to include the required number of fire drills. 2. A checklist was developed to assure that fire drills are conducted as required: once per shift/per quarter. Supporting documentation is attached.3. The Safety Officer will be responsible for completing the checklist and conducting the appropriate amount of fire drills.4. Deficiencies were corrected on September 27,</p>	09/27/2013			

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	<p>2. Review of fire drills conducted at the facility for calendar year 2012, indicated there was no fire drill conducted for the third shift in the first quarter (January, February, March).</p> <p>3. In interview, on 9-11-13 at 3:00 pm, employee #A5 confirmed the above and no further documentation was provided prior to exit.</p>		2013.		