| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150074 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 02/08/2013 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COMMUNITY HOSPITAL EAST | 1500 N RITTER AVE<br>INDIANAPOLIS, IN 46219 |

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| S000000 | This visit was for a standard licensure survey.<br><br>Facility Number: 005068<br><br>Survey Date: 2-4/8-13<br><br>Surveyors:<br>Jack I. Cohen, MHA<br>Medical Surveyor<br><br>John Lee, RN<br>Public Health Nurse Surveyor<br><br>Cleone Peterson<br>Medical Surveyor<br><br>QA: claughlin 02/15/13 | S000000 | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| S000322 | 410 IAC 15-1.4-1<br>GOVERNING BOARD<br>410 IAC 15-1.4-1(c)(6)(H)<br><br>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:<br>(6) Require that the chief executive officer develops policies and programs for the following:<br><br>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.<br>Based on review of documents and interview, the hospital failed to have policies and procedures reviewed at least triennially for 18 of 25 policies.<br><br>Findings:<br><br>1. Review of a hospital document entitled CORPORATE ADMINISTRATIVE POLICY/PROCEDURES INDEX (NUMERIC), dated November 2012, indicated the following 18 policies of 25 had not been reviewed since 2007 and 2008:<br><br>ADM. B-012A ADM. C-001 ADM. C-004<br>ADM. C-005 ADM. C-006 ADM. C-007<br>ADM. C-010 ADM. C-012 ADM. C-014 | S000322 | S 322: ADM B-012A was reviewed on 12/2010.S 322: ADM C-001: Hospital document entitled CORPORATE ADMINISTRATIVE POLICY/PROCEDURE INDEX (NUMERIC) negates need for continued use of this policy. Policy will be removed consistent with Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C).S 322: ADM C-004: Policy replaced by Network Policy IS-004: AUDIT AND LOGGING POLICY. Policy will be removed consistent with Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C). S 322: ADM C-005: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS | 04/15/2013 |

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| | ADM. C-015 ADM. C-016 ADM. C-017<br>ADM. C-018 ADM. C-019 ADM. C-021<br>ADM. C-023A ADM. C-024 ADM. C-025 (last reviewed 7/18/08)<br><br>2. In interview, on 2-7-13 at 10:00 am, the above was confirmed by hospital staff and no further documentation was provided prior to exit. | | §8(B). As COMP-001 §6(D)(4) defines a different naming category this policy will be deleted per Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) after new policy is posted.S 322: ADM C-006: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). As COMP-001 §6(D)(4) defines a different naming category this policy will be deleted per Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) after new policy is posted.S 322: ADM C-007: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). Initial review comments indicate this policy will be deleted as a Network Policy and converted to an Information Technology Departmental Policy. Should this policy be deleted, Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) will be followed after policy is posted as Information Technology Policy.S 322: ADM C-010: Policy is being reviewed consistent with Information | |

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| | | | Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). Initial review comments indicate this policy will be deleted as a Network Policy and converted to an Information Technology Departmental Policy. Should this policy be deleted, Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) will be followed after policy is posted as Information Technology Departmental Policy.S 322: ADM C-012: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). As COMP-001 §6(D)(4) defines a different naming category this policy will be deleted per Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) after new policy is posted.S 322: ADM C-014: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). Initial review comments indicate this policy will be deleted as a Network Policy. Should this policy be deleted, Network Policy | |

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| | | | COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) will be followed.S 322: ADM C-015: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). As COMP-001 §6(D)(4) defines a different naming category this policy will be deleted per Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) after new policy is posted.S 322: ADM C-016: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). As COMP-001 §6(D)(4) defines a different naming category this policy will be deleted per Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) after new policy is posted.S 322: ADM C-017: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). As COMP-001 §6(D)(4) defines a different naming category this policy will be deleted per Network | |

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| | | | Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) after new policy is posted. S 322: ADM C-018: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). Initial review comments indicate this policy will be deleted as a Network Policy. Should this policy be deleted, Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) will be followed.S 322: ADM C-019: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). Initial review comments indicate this policy will be deleted as a Network Policy. Should this policy be deleted, Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) will be followed.S 322: ADM C-021, ADM C-023A: Policies replaced by Network Policy IS-010: MOBILE DEVICE ACCEPTABLE USE POLICY. Policies will be removed consistent with Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C).S 322: | |

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| | | | ADM C-024: Network Policy COMP-012: HEALTH INFORMATION PRIVACY AND/OR SECURITY BREACH NOTIFICATION negates need for continued use of this policy. Policy will be removed consistent with Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C).S 322: ADM C-025: Policy is being reviewed consistent with Information Technology Departmental Policies and Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(B). As COMP-001 §6(D)(4) defines a different naming category this policy will be deleted per Network Policy COMP-001: NETWORK POLICIES AND PROCEDURES INSTRUCTIONS §8(C) after new policy is posted.Responsible Party: Chief Information Security Officer is the owner and will ensure the process for compliance.Future Prevention: Departmental policy is being developed that requires review of network policies in area of responsibility be initiated 24 months after last review date by Information Technology Security Department. If the Information Technology Security Department fails to initiate the review the Chief Technology Officer initiates review no later than 26 months after last review date. If the CTO fails to initiate the review the Chief Information Officer will | |

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| | | | initiate a review no later than 30 months after last review date. Departmental policy to be completed by 4/15/2013.4/15/2013 | |

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| S000932 | 410 IAC 15-1.5-6<br>NURSING SERVICE<br>410 IAC 15-1.5-6 (b)(4)<br><br>(b) The nursing service shall have the following:<br><br>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.<br>Based on document review and interview, the facility failed to ensure that the nursing staff developed and or documented care plan goals for 7 of 10 medical records (MR) reviewed (patient #20, 21, 22, 23, 24, 25 and 26).<br><br>Findings include:<br><br>1. Review of policy/procedure CLN-2071, Care Plan, Inpatient, indicated the following;<br>"Policy Statements:<br>3. The plan of care is initiated for all patients upon admission. It is individualized within 24 hours for all patients who are experiencing complications and/or individual problems with which they can not cope.<br>Procedure:<br>6. Goal documentation<br>a. Care plan and goals are to be reviewed every shift.<br>b. Goals are to be documented against at least once every 24 hours." | S000932 | Charts were reviewed from December 2012. A new significant policy change went into effect December 19, 2012 to reflect changes in Electronic Health Record after our implementation of EPIC. EPIC has had a transformational impact for nursing within the inpatient setting and use of care plans, particularly in the development of such plans. Significant changes in the development and documentation the plan of care to include goals and updates to stated goals every shift, per policy, has required extensive education for staff. This education began in June 2012 prior to implementation of the new record, additional structured education was provided in October 2012 to the RN's at Community Hospital East. A self-learning module has been provided to all clinical areas named, Patient Education and Plans of Care, to address the opportunities we have to improve documentation for specific goals as well as adherence to initiation | 03/15/2013 |

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| | This policy/procedure was last reviewed/revised on 12-19-12.<br><br>2. Review of the following patient MRs indicated the following;<br>Patient #20 was admitted to the facility on 12-22-12 and was discharged on 12-30-12. The patient's MR lacked documentation of the plan of care goals being documented against on 12-23, 24, 25, 26, 27 28 &29-12.<br>Patient #21 was admitted to the facility on 12-25-12 and was discharged on 12-31-12. The plan of care was started on 12-30-12.<br>Patient #22 was admitted to the facility on 12-20-12 and was discharged on 01310-13. The plan of care was started on 12-25-12 and the MR lacked documentation of the plan of care goals being documented against on 12-26, 27, 28, 29 &31-12.<br>Patient #23 was admitted to the facility on 12-25-12 and was discharged on 12-31-12. The patient's MR lacked documentation of a plan of care.<br>Patient #24 was admitted to the facility on 12-31-12 and was discharged on 01-04-13. The plan of care was started on 01-02-13.<br>Patient #25 was admitted to the facility on 01-04-13 and was discharged on 01-12-13. The patient's MR lacked documentation of the plan of care goals | | of an individualized care plan and within the first 24 hours of an inpatient stay. At times an observation or outpatient in a bed (no care plan required per policy) will convert to an inpatient in up to 72 hours after admission, making it appear that we have not initiated a care plan within the required time per policy. The Vice-President of Acute Care Services is the owner and will ensure compliance by ongoing monitoring of this process. Our plan to measure our success will be to monitor our Meaningful Use data weekly. The metric to measure is related to Pt. Education. Pt Ed is a significant part of each patients plan of care and is captured in our reports for Meaningful Use monitoring . | |

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| | being documented against on 01-06, 07, 08, 10 and 11-13.<br>Patient #26 was admitted to the facility on 12-28-12 and was discharged on 01-04-13. The patient's MR lacked documentation of the plan of care goals being documented against on 12-29 & 31-12 and 01-02 & 03-13.<br><br>3. On 02-08-13 at 0855 hours staff #50 confirmed the lack of documentation of plan of cares and or documentation of the plan of care goals being documented against daily. | | | |

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| S000952 | 410 IAC 15-1.5-6<br>NURSING SERVICE<br>410 IAC 15-1.5-6(d)<br><br>(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).<br>Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to follow an approved medical staff policy/procedure for one of seven blood transfusions reviewed.<br><br>Findings included:<br>1. On 2/4/13 between 4:00 p.m. and 5:00 p.m. a review was conducted of a policy/procedure titled: "Blood Component Administration NPP#: I-14B1 EFFECTIVE: 7/17/12" which stated: "B. 4. "Obtain baseline Respirations, Pulse, Temperature and B/P immediately prior to transfusion." B/P= (Blood Pressure)<br>2. Review of transfusion record #T5 indicated the prior vitals were taken at the same time as the transfusion was started: i.e. at 1820.<br>3. In interview on 2/5/13 between 10:00 a.m. and 11:00 a.m., staff person #1 | S000952 | As the Blood Management Officer I will own and audit this process for improvement. The Transfusion Record Form has been revised with the prompts included in the Vital Sign area to take the initial set **prior** to the start of the transfusion. It has been revised to facilitate the work flow to aid in compliance with completing the form accurately. A Blood Bag label has been developed and will be issued with each transfusion. It includes prompts for the correct timing of all vital signs which concurs with the Transfusion Record Form. Education is being conducted by the Nursing Congress and the Education department during orientation to maintain and sustain this process. Transfusion Record Forms are audited each month by Mid America Clinical Laboratories with a detailed report of any transfusion errors. The results are also discussed at the Lab/Nursing meeting. Errors | 03/30/2013 |

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| | acknowledged the prior vitals were not taken as the policy/procedure in effect at the time of the transfusion specified. | | are posted on the Nursing Congress sharepoint site for all nursing units review. | |

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| S001118 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8 (b)(2)<br><br>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:<br><br>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.<br>Based on document review and observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 3 instances.<br><br>Findings:<br><br>1. Review of a hospital policy entitled COMPRESSED GAS SAFETY, last revised in<br>year 2011, indicated cylinders must be stored in an upright position and secured by chain or other appropriate means. This applies to full as well as empty cylinders.<br><br>2. On 02-04-13 at 2:55 pm in the presence of employees #A16 and #A20, it was observed in the Clinical Engineering Office, there were 3 fire extinguishers on a cabinet unsecured by chain or holder. | S001118 | Corrective Action for S1118<br>Finding 2. – The small fire extinguishers from the shop vehicles were in the process of being exchanged for new ones. The process was completed on 2-4-13 at 3:15 PM. The new extinguishers were mounted in the vehicles. The old ones were taken to the Security office and placed in the approved storage system for removal from the facility. Clinical Engineering has ordered proper storage containers for the cylinders in each shop, to prevent the issue of unsecured cylinders from happening in the future in those areas. The Director of Clinical Engineering is the owner and will ensure the procedures are followed in the future by ongoing monitoring of the department.<br>Corrective Action for S118<br>Finding 3: This extinguisher was secured and mounted to a base stand on 02-04-13 by the | 02/11/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150074 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 02/08/2013 |
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| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST | | STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219 | |

| (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) COMPLETION DATE |
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| | 3. On 02-04-13 at 3:05 pm in the presence of employees #A16 and #A20, it was observed in the Housekeeping storage area, there was 1 fire extinguisher on the floor unsecured by chain or holder.<br><br>4. If any of the above extinguishers were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.<br><br>5. On 02-05-13 at 10:05 am in the presence of employee #A21, it was observed in the nursing station area of the offsite Medcheck Castleton facility, there were 3 alcohol-based hand sanitizers (ABHS) on the counter. It was also observed the area was carpeted and not sprinklered.<br><br>6. Location of the ABHS's in a carpeted and unsprinklered area posed a fire hazard if the flammable alcohol was sprayed or dropped onto the carpet. | | contractor owning the extinguisher. The contractor was informed and warned to make sure all extinguishers used in construction project areas are kept secured to the extinguisher stands at all times, whether in storage or not. Security Officers will help observe that proper fire extinguisher mounting is in place at all locations as the officers make rounds of the facility. The Director of Facilities Engineering is the owner of this process and will ensure that proper procedures are followed by the contractors in the future by ongoing monitoring of the construction project areas.<br>**Corrective Action for S1118 Finding 5: The alcohol based hand sanitizers were removed from all carpeted unsprinklered areas of the MedCheck Castleton on date of survey – 2/7/2013. The manager of the facility is the owner of this process and will ensure that no alcohol based hand sanitizers are in carpeted unsprinklered areas of the facility.** | |

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| S001150 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8 (c)(9)<br><br>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:<br><br>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.<br>Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.<br><br>Findings:<br><br>1. On 2-4-13 at 3:30 pm in the presence of employees #A16 and #A20, it was observed in the EMG/EEG treatment area there was a flexible hose connected to a water spigot without a backflow prevention device. | S001150 | Corrective Action for S1150<br>Finding 1: A vacuum breaker was added to the temporary connection hoses on 02-04-13 to correct this deficiency. All future temporary connections will have vacuum breakers added to prevent any possible back siphon. The Director of Facilities Engineering is the owner and will ensure that proper procedures are followed to install backflow prevention devices when required. | 02/11/2013 |

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| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST | | STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219 | |

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| S001186 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E)<br>(i)(ii)(iii)(iv)(v)<br><br>(f) The safety management program shall include, but not be limited to, the following:<br>(3) The safety program that includes, but is not limited to, the following:<br><br>(A) Patient safety.<br>(B) Health care worker safety.<br>(C) Public and visitor safety.<br>(D) Hazardous materials and wastes management in accordance with federal and state rules.<br>(E) A written fire control plan that contains provisions for the following:<br>(i) Prompt reporting of fires.<br>(ii) Extinguishing of fires.<br>(ii) Protection of patients, personnel, and guests.<br>(iv) Evacuation.<br>(v) Cooperation with firefighting authorities. | | | |
| | Based on document review and interview, the facility failed to conduct fire drills in accordance with hospital policy in 1 offsite facility.<br><br>Findings:<br><br>1. Review of a hospital policy entitled OUTER FACILITIES FIRE RESPONSE PLAN, indicated all ambulatory care and state board of health licensed outer facilities will conduct a fire drill once per quarter, per shift. | S001186 | Corrective Action for S1186:At the Medcheck Castleton facility staff work 12 hour shifts. Practice has changed to conduct fire drills to reflect two (2) nursing shifts. The Manager of the facility is the owner and will ensure that fire drills are conducted once per quarter, per shift per hospital policy. Ongoing monitoring will ocurr as evidenced by fire drill log documentation. | 03/30/2013 |

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|---|---|
| COMMUNITY HOSPITAL EAST | 1500 N RITTER AVE<br>INDIANAPOLIS, IN 46219 |

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| | 2. In interview via phone, on 2-6-13 at 1:45 pm, employee #A23 indicated the offsite Medcheck Castleton facility had 2 nursing shifts.<br><br>3. Review of documentation of fire drills conducted in 2012 at the above-stated facility, indicated there were no fire drills conducted on the second shift in quarters 1, 2 and 3.<br><br>4. The above-stated non-performance of fire drills was confirmed by employee #A23 and no further documentation was provided prior to exit. | | | |