Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2049	A. BUILDING 01 - MILLIE S CENTER, LLC B. WING _____	04/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLIE'S CENTER, LLC	600 NORTH HUDSON SILVER CITY, NM 88061

(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 01	OPENING REMARKS Surveyor: 25921 The following deficiencies were cited as a result of an annual survey conducted on April 14, 2009, for the Life Safety Code portion of the New Mexico Regulations Governing Requirements for Adult Residential Care Facilities 7.8.2 NMAC.	A 01	Scanned 5/12/09 JH	
A43	7 NMAC 8.2.43 Maintenance of Building & Grounds 7.8.2.43 MAINTENANCE OF BUILDING AND GROUNDS: The building(s) must be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following: A. All electrical, fire protection signaling, mechanical, telephone, water supply, heating, fire protection, and sewage disposal systems maintained in a safe and functioning condition, including regular inspections of these systems, (as applicable). B. The building, furniture and furnishings, storage areas, and grounds of the facility must be maintained in a safe, sanitary, and presentable condition at all times. C. Storage areas must be kept free from accumulation of refuse, discarded furniture, old newspapers, that create a fire hazard. D. Floors shall be maintained stable, firm, slip-resistant and free of tripping hazards. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.43 NMAC - Rn, 7 NMAC 8.2.43, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 25921 Refer to 7.8.2.43 - Maintenance of Building Based on observation and staff interview, the facility failed to assure the building be maintained and in good repair at all times, and failed to	A43	RECEIVED MAY 2009 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	

Division of Health Improvement

Corley Prewitt — Administrator — (X6) DATE 5-7-09

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

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A43	Continued From page 1 ensure the mechanical vents were working. This deficient practice affects all staff and residents throughout the facility. At the time of survey, the census was 12 and the licensed capacity was 16. The findings are: On April 14, 2009, between 8:30 am and 11:30 am, during a tour of the facility with the Owner, the Life Safety Code Surveyor observed the following: 1. The ventilation fan in bathroom located between resident rooms #10 and #11 did not work as when tested. 2. The ventilation fan in the bathroom located between resident #14 and #15 do not work when tested. 3. The ventilation fan in the bathroom located off of the living room did not work when tested. 4. The ventilation fan in the Janitors closet located across from the activities room did not work when tested. 5. The Owner stated that she would have the ventilation fans repaired or replaced as needed.	A43	A43 Ventilation fans (bathroom between rooms #10 and #11, bathroom between rooms #14 and #15, bathroom off the living room, and janitors' closet) have all been repaired. R2 vent fan will be installed no later than June 5, 2009.	
A48	7 NMAC 8.2.48 Lighting & Lighting Fixtures 7.8.2.48 LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances must be lighted to make the area clearly visible. B. Exits, exit-access ways, and other areas used at night by residents and staff must be illuminated by night lights or other continuous	A48		

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A48	Continued From page 2 lighting. C. Lighting fixtures must be selected and located to accommodate the needs and activities of the residents with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures must be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. A facility must be provided with emergency lighting to light exit passageways which will activate automatically upon disruption of electrical service. EXCEPTION: Adult residential care facilities with three (3) or fewer residents may have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.48 NMAC -Rn, 7 NMAC 8.2.48, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 25921 Reference NFPA 101, 2000 Edition Section 7.9.2 requires that the emergency illumination shall be provided for not less than 1.5 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1.5 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	A48		

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A48	Continued From page 3 Based on observation, record review and staff interview, the facility's practice failed to ensure periodic testing of the emergency lighting system. This deficient practice affects all staff and residents throughout the facility. At the time of survey, the census was 16 and the licensed capacity was 12. The findings are: On April 14, 2009, between 8:30 am and 11:30 am, during a tour of the facility with the Owner, the Life Safety Code Surveyor observed the following: 1. The emergency battery back up light fixture located at the Sun room failed to provide the necessary lighting of 1 ft-candle when tested. 2. The path of egress from the dinning room to the place of refuse outside of the building was not equipped with emergency lighting. 3. The Owner stated that the emergency lighting system would be corrected. Reference NFPA 101, 2000 Edition Section 7.9.3 requires that the emergency lighting system be tested every 30 days for at least 30 seconds and annually for at least 90 minutes. It also requires that written records of inspections and tests be maintained for inspection by the authority having jurisdiction. Based on observation, record review and staff interview, the facility's practice failed to ensure periodic testing of the emergency lighting system. This deficient practice affects all staff and residents throughout the facility. At the time of	A48	A48 The emergency battery back-up light fixture by the sun room has been replaced, and the batteries were dated so we will know when they are close to running out. We will install an emergency light on the path of egress from dining room. The Administrator is responsible for ensuring that it is accomplished no later than June 5th.	

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A48	Continued From page 4 survey, the licensed capacity of the facility was 16 and the census was 12. The findings are: On April 14, 2009, between 8:30 am and 11:30 am, during a review of the facility's maintenance records with the Owner and House Manager Executive Director, the surveyor observed the following: 1. There was no evidence of the monthly testing of the Emergency Exit light system was being conducted. 2. Evidence of annual testing of the Emergency Exit lighting system was not provided. 3. The House manager stated that, she was unaware of these requirements.	A48	A48 Continued The office manager and the assistant office manager are responsible for testing the Emergency Exit Light System every month. The office manager is organizing an electronic calendar to remind staff of when periodic testing is due. The Silver City Fire Marshall is responsible for the annual testing of the Emergency Exit Lighting System. The office manager is responsible for making sure the inspection takes place at the appropriate times. The office manager will include this testing in the electronic calendar which will be developed no later than June 5th.	
A49	7 NMAC 8.2.49 Elements of Facility Electrical System 7.8.2.49 ELEMENTS OF FACILITY ELECTRICAL SYSTEM: A. All fuse and breaker boxes must be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility must know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances must be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords are prohibited. EXCEPTION: The use of a multi-socket United Laboratories approved (U/L APPROVED) surge	A49		

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A49	Continued From page 5 protector with integrated circuit breaker no greater than six (6) foot in length is permitted. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.49 NMAC - Rn, 7 NMAC 8.2.48, 8-31-00] K This REQUIREMENT is not met as evidenced by: Surveyor: 25921 7.8.2.49 - Labelling of fuse and breaker boxes Based on observation and interview, the facility failed to ensure that all fuse and breaker boxes were labelled to indicate area of service in accordance with NFPA 70 (National Electrical Code). In the event the power requires to be terminated quickly at the electrical panels, these circuits would not be identifiable . This practice potentially affects all staff, residents, and visitors throughout the facility. At the time of survey, the licensed capacity of the facility was 16 and the census was 12. The findings are: On April 14, 2009, between 8:30 am and 11:30 am, during a tour of the facility with the Owner, the surveyor observed the following: 1. The facility breaker box located on the exterior of the building at the dining room had electrical panels identifying their spares within the panels directory. However, six (6) electrical breakers were labeled as "unused" but were in the "on" position. The electrical circuit breakers in use shall be labeled in the panels directory to indicate the area of the facility each circuit breaker provides service. All circuit breakers labeled "spares" shall be kept in the "off" position.	A49	A49 The breaker boxes located outside the dining room and in the medication room have already been relabeled to appropriately reflect where each circuit breaker provides service and/or spare (as opposed to unused). The spare breakers are all in the off position.	

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A49	Continued From page 6 2. The facility breaker box located in the medication room of the building had electrical panels identifying their spares within the panels directory. However, three (3) electrical breakers were labeled as "unused" but were in the "on" position. The electrical circuit breakers in use shall be labeled in the panels directory to indicate the area of the facility each circuit breaker provides service. All circuit breakers labeled "spares" shall be kept in the "off" position. 3. The Owner stated during interview, "All electrical circuits will be properly identified."	A49		
A51	7 NMAC 8.2.51 Exits 7.8.2.51 EXITS: A. Each facility must have at least two (2) approved exits, that do not involve windows and which are remote from each other. At least one path of travel shall be provided that does not traverse any space exposed to unprotected vertical openings or common living spaces. B. Facilities with ten (10) or more residents shall have each exit clearly marked with signs having letters at least six inches (6") high whose principal strokes are at least 3/4 of an inch wide. Exit signs shall be visible at all times. C. Exits must be clear of obstructions at all times. D. Exits, exit paths, or means of egress shall not pass through hazardous areas, storerooms, closets, bedrooms, or spaces subject to locking. E. Sliding doors are not acceptable as a required exit. EXCEPTION: Adult residential care facilities with three (3) or fewer residents may have sliding doors as required exits. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97;	A51		

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A51	Continued From page 7 7.8.2.51 NMAC - Rn, 7 NMAC 8.2.51, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 25921 Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. Based on observation and staff interview, the facility's practice failed to ensure exit signs are continuously illuminated and are arranged readily visible to provide clear direction of travel to the nearest exit. This deficient practice potentially affects all staff, residents and visitors throughout the facility. At the time of survey the facility is licensed for 16 residents and the current census is 12, findings are: On April 14, 2009, between 8:30 am and 11:30 Am, during a tour of the facility with the Owner, the Life Safety Code Surveyor observed the following 1. When tested the exit sign located at the Sun room and under battery power did not illuminate. 2. When tested the exit sign located at the Main Entrance and under battery power did not	A51	A51 New batteries have been installed (and dated) in the exit signs at the Sun Room and the Main Entrance. The maintenance person is moving the exit sign in the dining room to the other side of the door. The Administrator is responsible for making sure this completed no later than June 5, 2009. In addition, the Administrator is responsible for ensuring that the maintenance person installs an emergency exit sign in the Library no later than June 5th.	

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A51	Continued From page 8 illuminate. 3. The exit sign located in the Dining room was covered with plant growth and was not visible. 4. The exit path through the Library was not marked with an exit sign as required. 5. The Owner stated that she would ensure that the exit signs were illuminated and visible.	A51		
A59	7 NMAC 8.2.59 Fire Clearance & Inspections 7.8.2.59 FIRE CLEARANCE AND INSPECTIONS: A. Written documentation from the State Fire Marshall's office or Fire Prevention Authority having jurisdiction indicating a facility's compliance with applicable fire prevention codes shall be submitted to the Licensing Authority prior to issuance of a initial license. B. Each facility shall request from the local fire prevention authorities an annual fire inspection. If the policy of the local fire department does not provide for annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7-1-64, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.59 NMAC - Rn, 7 NMAC 8.2.59, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 25921 Based on documentation review and interview, the facility failed to keep a record of the annual	A59		

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A59	Continued From page 9 inspection report of the Local Fire Authority, as required by the Life Safety Code (NFPA 101) and NMAC 7.8.2. This deficient practice affects all staff and residents throughout the facility. At the time of survey, the census was 16 and the licensed capacity was 12. The findings are: On April 14, 2009, between 8:30 am and 11:30 am, during a review of the facility's documentation with the Owner and House Manager, the Life Safety Code Surveyor observed the following: 1. There was no evidence of documentation of an annual local Fire Authority inspection having been conducted within the last 12 months. The last documented inspection from the local Fire Authority was conducted on 6/14/07. 2. The House Manager stated that the local Fire Authority would be conducting an inspection today (4/14/09).	A59	A59 The Silver City Fire Marshall conducted an annual inspection on April 16, 2009 (documentation enclosed).	
A60	7 NMAC 8.2.60 Fire Alarms, Smoke Detectors, and other Equip 7.8.2.60 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. FIRE ALARM SYSTEM: A manual fire alarm system shall be provided. The manual fire alarm must be inspected and approved in writing by the fire authority having jurisdiction. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a fire alarm system. B. SMOKE AND HEAT DETECTION: Approved smoke detectors shall be installed on each floor to provide when activated an alarm which is audible in all sleeping areas. Areas of assembly such as the dining and living room	A60		

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A60	Continued From page 10 must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors must be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all enclosed kitchens and also powered by the house electrical service. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.60 NMAC - Rn, 7 NMAC 8.2.60, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 25921 Based on documentation review and staff interview, the facility's practice failed to ensure the fire alarm system and its components are inspected and maintained in accordance with (NFPA 72 H-1984,4-1), National Fire Alarm Code which requires sensitivity testing of the smoke detection devices. This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility is 16, the census during the survey was 12. The findings are: On April 14, 2009 , between 8:30 am and 11:30 am, during a review of the facility maintenance records with the Owner and the House Manager, the Life Safety Code Surveyor observed the following. 1. There was no evidence of sensitivity testing was performed on the smoke detectors.	A60	A60 In the Silver City Fire Marshall's annual inspection of April 16, 2009, he stated that the smoke detectors were functioning properly on his report. Accent Fire Safety Associates, the company that conducts our quarterly water-based fire protection system, instructed us to not install the red rubber nozzles because our system would not be in compliance with the manufacturer's specifications and we could not pass the quarterly inspections.	

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A60	Continued From page 11 2. The Owner and House Manager acknowledged this finding at the exit conference. Based on observation, record review and staff interview, the facility's practice failed to assure cooking facilities are protected and inspected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility is 16, the census during the survey was 12. The findings are: On April 14, 2009 , between 8:30 am and 11:30 am, during a review of the facility maintenance records with the Owner and the House Manager, the Life Safety Code Surveyor observed the following. 1. The range hood inspection report dated 1/13/09 indicated that the extinguishment system is not compliant with the UL-300 standards (wet system). 2. During an interview, the Owner stated that the facility would upgrade to meet the UL-300 standards. Based on observation, record review and staff interview, the facility's practice failed to ensure that the fire alarm system and its components are maintained and inspected in accordance with NFPA 72 (National Fire Alarm Code). This deficient practice potentially affects all residents	A60		

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A60	Continued From page 12 and staff throughout the facility. The licensed capacity of the facility is 16, the census during the survey was 12. The findings are: On April 14, 2009 , between 8:30 am and 11:30 am, during a tour of the facility with the Owner, the Life Safety Code Surveyor observed the following: 1. Documentation indicating that the fire alarm had been inspected within the last year was not in evidence. 2. The Owner stated that the facility had encountered problems with the contractor that installed the fire alarm system and was pursuing a new contractor to address the facility's needs.	A60		
A61	7 NMAC 8.2.61 Automatic Fire Protection (sprinkler) System 7.8.2.61 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Where an automatic fire protection (sprinkler) system is installed for total or partial coverage, the system shall be in accordance with NFPA 13 or NFPA 13D as applicable. [4-7-97; 7.8.2.61 NMAC - Rn, 7 NMAC 8.2.61, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 25921 Based on record review and staff interview, the facility's practice failed to provide documentation of quarterly testing, and to ensure the sprinkler system was maintained in accordance with NFPA 13, (Standard for the Installation, Testing and Maintenance of Water-Based Fire Protection Systems) and NFPA 25, (Standard for the	A61	A61 Accent Fire Safety has agreed to come for a "quarterly" inspection well before June 5. The Office Manager is in charge of making sure this inspection occurs on time and that subsequent inspections happen on time via our to-be-developed (before June 5) electronic calendar.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2049	A. BUILDING 01 - MILLIE S CENTER, LLC B. WING _____	04/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLIE'S CENTER, LLC	600 NORTH HUDSON SILVER CITY, NM 88061

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A61	Continued From page 13 Inspection, Testing and Maintenance of Water-Based Fire Protection Systems). This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility is 16, the census during the survey was 12. The findings are: On April 14, 2009, between 8:30 am and 11:30 am, during a review of the facility maintenance records with the Owner and House Manager, the Life Safety Code Surveyor observed the following: 1. The documentation for the fire sprinkler system inspection was dated 11/10/08. There were no other current sprinkler system inspection reports in evidence for the last 5 months, which exceeds the quarterly inspection requirements. 2. The House Manager stated the facility would provide quarterly testing of the sprinkler system. Based on observations and interview, the facility failed to assure that the building elements, which are attached to the building, are equipped with a sprinkler system and used by the facility residents, staff and visitors, was installed and maintained in accordance with the Life Safety Code and NFPA 13. Roofing and Canopies that extend more than 4 feet from the building and are connected to the building must be equipped with sprinklers. This practice potentially affects all staff, residents, and visitors throughout the facility. At the time of survey, the licensed capacity of the facility was 16 and the census was 12. The findings are: On April 14, 2009, between 8:30 am and	A61	A61 Millie's water-based fire protection systems inspector is the past fire marshall, Craig Pfeiffer of Accent Fire Safety Associates, P.C. He has assured us that the requirement for outside sprinkler systems applies only to new construction. Until this is disproven, we respectfully refuse to install the outside sprinkler system.	

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A61	Continued From page 14 11:30 am, during a tour of the facility with the Owner, the surveyor observed the following: 1. At the Main Entrance to the facility used by staff and venders was a canopy that measured 12 feet by 60 feet that was not protected by a sprinkler system. 2. Beyond the Dining room exit of facility attached to the building was a canopy that measured 30 feet by 30 feet, and was not protected by a sprinkler system. 3. The Owner acknowledged these findings.	A61		
A63	7 NMAC 8.2.63 Staff & Resident Fire & SafetyTraining 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be	A63		

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A63	Continued From page 15 taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at least one (1) fire drill each month: (1) Fire drills must be held at different times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills. (3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes. (5) The local fire department should be requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 25921 Based on record review and staff interview, the facility's practice failed to ensure that the fire drills are conducted once per month at different times of the day, in accordance with NMAC 7.8.2.63 D. This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility is 16, the census during the survey was 12. The findings are: On March 10, 2009 , between 12:00 pm and 1:30 pm, during a review of the facility maintenance records with the House Manager,	A63	A63 Deficiences noted. We were not aware that we needed to conduct fire drills on every shift. Our plan is to have at least one fire drill on each shift quarterly. The Administrator and Office Manager are both in charge of making this happen. The Office Manager will include the drills in the electronic calendar.	

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A63	Continued From page 16 the Life Safety Code Surveyor observed the following. 1. During interview, the House Manager stated that there are three (3) shifts per day as follows: Day shift from 6:00 am to 2:00 pm. Evening shift from 2:00 pm to 9:00 pm. Night shift from 9:00 pm to 6:30 am. 2. The facility's records did not show fire drills being conducted on the Evening shift for the past 12 months (2 pm to 9 pm). 2a. There were no records of fire drills ever being conducted on the Evening shift. 3. The facility's records did not show fire drills being conducted on the Night shift for the past 12 months (9 pm to 6:30 am). 3a. There were no records of fire drills ever being conducted on the Night shift. 4. The House Manager stated that the facility would begin conducting fire drills on the evening and night shifts.	A63		