

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/17/2014
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NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703
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K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 485.623(d).</p> <p>Survey Date: 03/17/14</p> <p>Facility Number: 005037 Provider Number: 151315 AIM Number: 100267970A</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist; Mark Bugni, Life Safety Code Specialist; and Brett Overmyer, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Cameron Memorial Community Hospital Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.</p> <p>This two story facility with a basement and a subbasement was determined to be of Type II (222) construction and partially sprinklered. The facility has a</p>	K010000		
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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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K010018	<p>fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 25 and had a census of 14 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 30 ground floor corridor doors and 7 of 70 first floor corridor doors did not have an impediment to closing. This deficient</p>	K010018	<p>1. a.) A foam block taped in place and restricting the complete closure of the dutch door entry to data processing was removed during the survey <b>on March 17, 2014</b>, thus correcting the deficiency. The</p>	04/04/2014			

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	<p>practice could affect any patient as well as staff and visitors on the ground or first floor of the hospital.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director during a tour of the facility on 03/17/14 from 10:45 a.m. to 12:45 p.m. and then from 1:15 p.m. to 2:45 p.m., the following was noted:</p> <p>a. The Dutch door of the Data Processing/Information Technology office had a piece of foam rubber taped over the latching device of the door.</p> <p>b. The doors to the Gift Shop, Cardiopulmonary # 1, # 2, # 3, the Cardiopulmonary office, the Radiologist's Reading room and the CTS scan room were propped open by metal kick-down doorstops attached to the bottom of the doors. Based on interview at the time of observation, the Facilities Director acknowledged the doors were propped open with the attached door stops.</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 90 second floor room doors would resist the passage of smoke with no impediment to closing the doors. This deficient practice affects two patients who reside in room number 270 and 272, and 4 patients on the East Obstetric Hall,</p>		<p>Facilities Director, along with IT staff occupying this area will be responsible to assure item is not used further.</p> <p>b.) Affixed metal kick down door stops have been removed from all seven (7) locations: gift shop, cardio treatment rooms 1, 2 and 3, cardiopulmonary office, radiologist reading room and CT scan room <b>as of April 4, 2014</b>, thus correcting deficiency. The Facilities Director will be responsible to assure these are not used further.</p> <p>2. Affixed metal kick down door stops have been removed from patient room doors at rooms 270 and 272 <b>as of April 4, 2014</b>. Additionally, four (4) ½ in. holes (where door closure had previously been installed) have been filled/sealed with tight fitting bolts <b>as of April 4, 2014</b>. The aforementioned activities have corrected the deficiency. The Facilities Director will be responsible to continue to monitor these circumstances.</p>				

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K010020	<p>located near the nurse supervisor office.</p> <p>Findings include:</p> <p>Based on observations on 03/17/14 during a tour of the second floor with the Bio-Medical Engineer from 9:45 a.m. to 12:45 p.m., patient room numbers 270 and 272 each had a metal kickstand screwed to the bottom of the room doors which were propped open. Furthermore, the East Obstetrics Hall Nurse Supervisor office door had four, one half inch circular holes through the top of the nonlatching side of the door. The metal kickstands attached to the doors of patient rooms 270 and 272 and the holes in the door to the nurse supervisor room office were verified by the Bio-Medical Engineer at the time of observations.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 1 of 4 stairways, a vertical opening, was enclosed with construction having a fire resistance rating of at least one hour. This</p>	K010020	A three (3) inch diameter circular opening in the center stairwell, outside the elevator equipment at the penthouse (3rd building level) will be filled/sealed with appropriate and approved fire caulking material	04/04/2014
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K010025	<p>deficient practice could affect any patient residing on the Medical Surgery Hall who would use the medical surgery center stairway for evacuation.</p> <p>Findings include:</p> <p>Based on observation on 03/17/14 at 12:05 p.m. with the Bio-Medical Engineer, the center medical surgery stairway wall outside the third floor elevator equipment room had a three inch diameter circular opening in the stairway wall between the stairway and the elevator equipment room with no fire stopping material used to seal the opening. This was verified by the Bio-Medical Engineer at the time of observation.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the</p>	K010025	<p><b>by April 4, 2014</b>, thus correcting the deficiency. The Facilities Director will be responsible to continue to audit and monitor building penetrations.</p> <p>A six inch by one inch breach in</p>	04/04/2014			

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	<p>facility failed to ensure 2 of 90 second floor room wall smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any patient using ambulatory health care and obstetrics.</p> <p>Findings include:</p> <p>Based on observations with the Bio-Medical Engineer on 03/17/14 during a tour of the second floor Ambulatory Health Care Hall and Obstetrics Hall from 10:10 a.m. to 11:45 a.m., the Ambulatory Health Care Hall data closet north wall had a six inch by one inch open area above the electric panel with no drywall, and the Obstetrics Hall mechanical room number ABHU4 south wall had a two inch circular opening around a cable bundle which was not fire stopped and a three foot open area with the drywall missing. This was verified by the Bio-Medical Engineer at the time of observations.</p>		<p>smoke barrier wall in 2nd floor Ambulatory Care data closet (above electrical panel 2 each) will be repaired/sealed <b>by April 4, 2014</b>. An additional opening in smoke barrier wall of OB mechanical room (unit AHU 4) will be repaired/sealed <b>by April 4, 2014</b>. The Facilities Director will be responsible to continue to audit and monitor smoke barrier wall(s) integrity.</p>				

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K010029	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 6 hazardous areas, such as combustible storage room over 50 square feet in size would automatically close and latch into the door frame. This deficient practice could affect any patient on the Medical Surgery Hall.</p> <p>Findings include:</p> <p>Based on observation on 03/17/14 at 10:20 a.m. with the Bio-Medical Engineer, the Medical Surgery Hall surgery storage room which measured two hundred sixty square feet in size and stored combustible cardboard boxes of paper supplies and plastic surgery equipment had a metal kickstand screwed to the bottom of the door which propped the room door open and prevented the self closing device from</p>	K010029	A six inch by one inch breach in smoke barrier wall in 2nd floor Ambulatory Care data closet (above electrical panel 2 each) will be repaired/sealed <b>by April 4, 2014</b> . An additional opening in smoke barrier wall of OB mechanical room (unit AHU 4) will be repaired/sealed <b>by April 4, 2014</b> . The Facilities Director will be responsible to continue to audit and monitor smoke barrier wall(s) integrity.	04/04/2014			

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K010038	<p>automatically closing and latching the door. This was verified by the Bio-Medical Engineer at the time of observation.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 3 of 4 first floor exits which continued more than one half story beyond the level of exit discharge, were interrupted at the level of exit discharge by partitions, doors, or other effective means.</p> <p>LSC 7.7.3 requires the exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means. This deficient practice could affect all patients in the facility who would use the first floor east exit near the chiller deck, the first floor west exit near the housekeeping storage area, and the first floor north west exit near the operating</p>	K010038	<p>1. Stair decent interrupter(s) (gates) will be installed <b>by April 16, 2014</b> at appropriate exit points in two (north and east) of three stairway(s) indicated (south stair gate was in place at time of survey, March 17, 2014). The Facilities Director will be responsible to coordinate the completion of this work and continue to monitor appropriateness of stair way egress routes.</p> <p>2. Appropriate railing will be installed contiguous with landing exit area of east stairway <b>by April 16, 2014</b>. The Facilities Director will be responsible to coordinate the completion of this work and continue to monitor appropriateness of stair way egress routes.</p>	04/16/2014

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	<p>room storage area.</p> <p>Findings include:</p> <p>Based on observations on 03/17/14 during a tour of the second floor with the Bio-Medical Engineer from 9:45 a.m. to 12:45 p.m., the second floor Sleep Center Hall stairway exit, the second floor Patient Hall stairway exit, and the second floor Obstetrics Hall stairway exit discharged into enclosed stairways to the first floor and exited into the parking lot. Furthermore, the three first floor exit stairways continued to the basement and lacked stairway interrupters at the first floor level of discharge. This was verified by the Bio-Medical Engineer at the time of observations.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 second floor exit accesses leading to the first floor discharge path with stairs was provided with a handrail. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within</p>						

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K010062	<p>dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient practice could affect any patients using the second floor Obstetrics Hall East stairway exit enclosure during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 03/17/14 at 12:15 p.m. with the Bio-Medical Engineer, the second floor Obstetrics Hall East stairway discharged to the first floor East Wing exit onto an asphalt sidewalk. Furthermore, the sidewalk surface extended fifteen feet to two stairs and up to a twelve foot landing with one stair on the opposite side of the landing and onto the parking lot. The stairs on both sides of the landing lacked a handrail. The lack of handrail on each side of the fifteen foot sidewalk landing was verified by the Bio-Medical Engineer at the time of observation.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p>						

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	<p>1. Based on observation and interview, the facility failed to replace 1 of over 300 second floor sprinklers covered in brown corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect any patient on the Sleep Center Hall.</p> <p>Findings include:</p> <p>Based on observation on 03/17/14 at 11:55 a.m. with the Bio-Medical Engineer, the Sleep Center Hall staff office closet sprinkler was completely covered in brown corrosion. This was verified by the Bio-Medical Engineer at the time of observation.</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section</p>	K010062	<p>1. A deteriorated sprinkler head in a sleep center closet, in the staff office area, will be replaced <b>by April 16, 2014</b>. The Facilities Director will be responsible to coordinate completion of this work and will also schedule completion of a survey of all sprinkler heads condition.</p> <p>2. An internal sprinkler system inspection with appropriate documentation will be completed/provided <b>by April 16, 2014</b>. The Facilities Director will be responsible to coordinate completion of this sprinkler system inspection as required.</p>	04/16/2014			

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	<p>10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Bio-Mechanical Engineer on 03/17/14 at 10:15 a.m., the Shambaugh &amp; Son's sprinkler inspection report titled "Sprinkler Inspection Certificate" dated 02/19/14 provided a check mark in a "yes" box that an internal pipe inspection had been done. The sprinkler inspection documentation did not indicate when the most recent internal inspection of the dry sprinkler system had been done. Based on an interview with the Bio-Mechanical Engineer at the time of record review, 2009 was thought to be when the internal inspection of the dry sprinkler system had been done but specific documentation of the internal pipe inspection was not available for review.</p>						

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K010070	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>1. Based on observation, record review, and interview; the facility failed to enforce the policy for the use of portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect at any patient, staff or visitor throughout the hospital.</p> <p>Findings include:</p> <p>Based on a review of the hospital's written portable space heater policy on 03/17/14 at 9:30 a.m. with the Facilities Director, the written policy stated portable electric space heaters may be used in staff offices under supervision by facility staff, turned off when not in use, and hospital maintenance staff must approve each space heating device to ensure the heating elements do not exceed 212 degrees Fahrenheit. Based</p>	K010070	<p>1. a.) Any/all portable space heaters in the Emergency Department (patient care area) will be collected and removed <b>by April 16, 2014</b>. The Facilities Director will be responsible for the assignment and follow through of space heater(s) collection and removal in all patient care areas.b) All space heaters remaining in use (approved non-sleeping and office staff areas only) will be inventoried and assigned a control number. An annual testing PM will be established to confirm heating elements do not exceed 212 degrees fahrenheit. This deficiency will be completed by <b>April 16, 2014</b>. The Facilities Director will be responsible for the execution of all deficiency correction aspects including a policy revision to reflect these changes.</p> <p><b>2..</b> <b>Deficiency/corrective</b></p>	04/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/17/2014	
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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	<p>on an interview with the Facilities Director on 03/17/14 at 9:35 a.m., there was no written evidence to indicate the heating elements of the electric portable space heaters in use did not exceed 212 degrees Fahrenheit. Based on observations on 03/17/14 during a tour from 10:45 a.m. to 12:45 p.m. and then from 1:15 p.m. to 2:45 p.m., the following was noted:</p> <p>a. At least three electric space heaters were observed in use in the Emergency Department (ED) at two workstations and the nurses station which were part of a patient care area.</p> <p>b. An electric space heater was observed in use in the Recertification office which was open to a patient/visitor waiting area. Based on interview with the Facilities Director at the exit conference at 3:00 p.m. on 03/17/14, the facility has purchased and distributed at least sixty electric space heaters throughout the hospital and the facility does not have documentation that the heating elements of the space heaters will not exceed 212 degrees Fahrenheit.</p> <p>2. Based on observation, interview, and record review; the facility failed to ensure evidence was provided for portable space heating devices used in nonsleeping staff and employee areas to ensure the heating elements of the</p>		<b>action plan, repeat of 1. a. and b.</b>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/17/2014
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703		
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	<p>devices do not exceed 212 degrees Fahrenheit. This deficient practice could affect all patients on the second floor in the event a staff used portable space heater started fire.</p> <p>Findings include:</p> <p>Based on a review of the hospital's written portable space heater policy on 03/17/14 at 9:30 a.m. with the Facilities Director, the written policy stated portable electric space heaters may be used in staff offices under supervision by facility staff, turned off when not in use, and hospital maintenance staff must approve each space heating device to ensure the heating elements do not exceed 212 degrees Fahrenheit. Based on an interview with the Facilities Director on 03/17/14 at 9:35 a.m., there was no written evidence to indicate the heating elements of the electric portable space heaters in use did not exceed 212 degrees Fahrenheit. Based on observations on 03/17/14 during a tour of the second floor with the Bio-Medical Engineer from 9:45 a.m. to 12:45 p.m., the sleep center staff office, the rehabilitation gym director office, and the director services office each had a portable electric space heater in use. Based on observation of the three space heaters, there was no written</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/17/2014	
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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K010072	<p>information on each space heater to indicate the maximum temperature of the heating elements. The lack of written evidence the portable space heaters' heating elements did not exceed 212 degrees Fahrenheit was verified by the Bio-Medical Engineer at the time of observations.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 2 of 4 exits. This deficient practice could affect staff and visitors throughout the ground floor of the hospital.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director during a tour of the facility on 03/17/14 from 10:45 a.m. to 12:45 p.m. and then from 1:15 p.m. to 2:45 p.m., the following was noted:</p>	K010072	<p>Corridor and exit area obstructions and stored items will be removed/eliminated in ground floor north exit stairwell, dietary corridor and ground floor south exit stairwell</p> <p><b>by April 16, 2014.</b> The Facilities Director will be responsible to accommodate these corrective measures and to establish a routine inspection schedule for facility exit routes.</p>	04/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/17/2014
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NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703
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K010130	<p>a. The ground floor north exit stairwell had storage of a salad bar, four coolers and assorted dietary equipment obstructing the exit.</p> <p>b. The dietary corridor leading to the ground floor north exit had storage of a desk, chairs, file cabinets and carts obstructing the means of egress.</p> <p>c. The ground floor south exit stairwell had storage of a paint cart, paint cans, a ladder and sawhorses obstructing the exit.</p> <p>Based on interview at the times of observation, the Facilities Director acknowledged the aforementioned conditions.</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999</p>	K010130	The vertical rolling fire door between the kitchen (dishwashing area) and the dining room will be inspected for proper operation and tagged accordingly <b>by April 16, 2014</b> . An established agreement with a contract service vendor will ensure routine inspection once annually and associated	04/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/17/2014	
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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	<p>Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any staff or visitor using the ground floor dining room adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 03/17/14 during the tour from 10:45 a.m. to 12:45 p.m. with the Facilities Director, there was a rolling fire door protecting the opening from the kitchen to the main dining room without an attached inspection tag. Based on interview during paperwork review from 9:45 a.m. to 12:45 p.m. with the Facilities Director, the Facilities Director acknowledged there was no documentation of an annual inspection or test since installation to check for proper operation and full closure of the vertical rolling fire door.</p>		inspection documentation will be maintained on file in the Facilities office. The Director of Facilities will be responsible for deficiency correction and future maintenance of these inspection services.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/17/2014	
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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K010147	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure high current draw electrical devices were not plugged into power strips as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director during a tour of the facility on 03/17/14 from 1:15 p.m. to 2:45 p.m., the following was noted:</p> <p>a. The Cardiopulmonary office had a microwave plugged into a power strip. b. The Business office had a refrigerator plugged into a power strip.. c. The Recertification office had a</p>	K010147	<p><b>a. b. and c</b> Microwave(s) and refrigerator(s) (along with any higher demand electrical equipment) will not be plugged into power strips. Power strips at occurrence locations noted in survey in cardiopulmonary office, business office, and central scheduling (referred to in survey as "recertification") were removed/eliminated during survey on <b>March 17, 2014</b>, thus correcting the deficiency. The Facilities Director will be responsible for continuing to audit/monitor facility power strip usage with higher electrical demand equipment.</p>	03/17/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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K010154	<p>refrigerator plugged into a power strip. Based on interview at the times of observation, the Facilities Director acknowledged the aforementioned conditions.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy indicating procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. in order to protect 14 of 14 patients. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be</p>	K010154	<p>The hospital's "Fire Watch" policy/procedure will be revised <b>by April 16, 2014</b>. This revision will reflect required notification of authority having jurisdiction including the Indiana State Department of Health. The Facilities Director will be responsible for completing this revision to our "Fire Watch" policy/procedure.</p>	04/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/17/2014	
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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K010155	<p>notified. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's fire watch policy and procedure on 03/17/14 during paperwork review from 9:45 a.m. to 12:45 p.m. with the Facilities Director, the fire watch procedure for an out of service sprinkler system was not complete. The policy and procedure did not include notification to the Indiana State Department of Health which is an authority having jurisdiction. Based on interview at the time of record review, the Facilities Director acknowledged the fire watch policy and procedure did not include notification to the Indiana State Department of Health.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure its written</p>	K010155	<p>Repeat of K 154 deficiency and corrective action. The hospital's "Fire Watch"</p>	04/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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	<p>fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. in order to protect 14 of 14 patients. This deficient practice could affect all occupants of the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire watch policy and procedure on 03/17/14 during paperwork review from 9:45 a.m. to 12:45 p.m. with the Facilities Director, the fire watch procedure for an out of service fire alarm system was not complete. The policy and procedure did not include notification to the Indiana State Department of Health which is an authority having jurisdiction. Based on interview at the time of record review, the Facilities Director acknowledged the fire watch policy and procedure did not include notification to the Indiana State Department of Health.</p>				<p>policy/procedure will be revised <b>by April 16, 2014</b>. This revision will reflect required notification of authority having jurisdiction including the Indiana State Department of Health. The Facilities Director will be responsible for completing this revision to our "Fire Watch" policy/procedure.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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K010211	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</li> </ul> <p>Based on observation and interview, the facility failed to ensure 1 of 1 alcohol based hand rub dispensers within the CTS scan room was not installed over an ignition source. This deficient practice could affect any patient within the CTS scan room.</p> <p>Findings include:</p> <p>Based on observation and interview on 03/17/14 with the Facilities Director during the tour from 1:15 p.m. to 2:45 p.m., the CTS scan room had an alcohol based hand rub dispenser mounted on the wall directly above an electric outlet. Based on interview with the Facilities Director, it was acknowledge the alcohol based hand rub dispenser was mounted</p>	K010211	<p>Alcohol based hand sanitizers mounted directly over electrical receptacles in the first floor CT scan room and the second floor OB patient room 240 will be removed and relocated in accordance with criteria guidelines. Alcohol hand sanitizers in these locations will be relocated <b>by April 16, 2014</b>. The Facilities Director will be responsible to assign and follow through on these requests.</p>	04/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151315	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/17/2014
NAME OF PROVIDER OR SUPPLIER  CAMERON MEMORIAL COMMUNITY HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703		
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	<p>directly above an electrical outlet.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 20 second floor patient rooms' alcohol based hand rub dispensers was not located over an ignition source. This deficient practice could affect one patient in the Obstetrics Hall, room 240.</p> <p>Findings include:</p> <p>Based on observation on 03/17/14 at 11:35 a.m. with the Bio-Medical Engineer, the second floor Obstetrics Hall, room 240 had a fifteen ounce container of alcohol based hand sanitizer mounted on the west wall directly above an electric outlet. This was verified by the Bio-Medical Engineer at the time of observation.</p>				