STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005037	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMERON MEMORIAL COMMUNITY HOSPITAL INC	416 E MAUMEE ST ANGOLA, IN 46703

(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
S 000	INITIAL COMMENTS This visit was for a licensure review of negative pressure patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP. Facility Number: 005037 Survey Date: 11/4/21 The following patient rooms were successfully verified as negative pressure: A, B, C, D, LDR2, 3, 4, 5, 10, 206, 207, 208, 209, 221, 223, 224, 225, 226, 227, 228, 229 and 230. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 11/19/2021	S 000		