STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151300	A. BUILDING -- B. WING	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY HOSPITAL OF BREMEN INC	1020 HIGH RD BREMEN, IN 46506

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 485.625 Survey Date: 06/10/25 Facility Number: 005097 Provider Number: 151300 AIM Number: 100269320A At this Emergency Preparedness survey, Community Hospital of Bremen was found in not compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 485.625 The facility has 24 certified beds. At the time of the survey, the census was 7. Quality Review completed on 06/19/25	E 0000		
E 0031 Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(Emergency Officials Contact Information Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EPP) includes (2) Contact information for the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance in accordance with 485.625(c)(2) This deficient practice could affect all occupants. Findings include:	E 0031	Correction Activities: The Emergency Preparedness Coordinator created an Emergency Agencies Contact List containing contact information for the following external agency resources: · Federal (FEMA, FBI) · Tribal (Pokagon Band of Potawatomi) · State (IDOH, IDHS, INDOT, NWS)	06/30/2025

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

Andrew J Hoffmann | Quality Manager | 07/03/2025

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	Based on records review with the Emergency Preparedness Coordinator on 06/10/25 at 10:43 a.m., the EPP did not include Federal, State, tribal, regional, and other sources of assistance contact information. Based on an interview at 10:43 a.m., the Emergency Preparedness Coordinator stated the contact information for Federal, State, tribal, regional, and other sources of assistance contact information could not be found. This finding was reviewed with the President, Facilities Services Coordinator, Emergency Preparedness Coordinator, and Maintenance Tech II during the exit conference at 3:10 p.m.		· Local/Regional (EMS, Health Departments, EMA, Police, Fire, Schools, Hospitals, Utilities The list was created on 6/28/25 and incorporated into the Emergency Operations Plan as 'Attachment 1.0' on 6/30/25 following approval by the Hospital Leadership Committee. Education: The Vice President of Nursing & Operations sent an educational email to the entire hospital staff on 6/30/25 informing them of the additional external resources available as part of the Emergency Operations Plan. Leaders were also notified in person at the monthly Leadership Forum. Ongoing education occurs annually via a mandatory computer-based learning module focusing on the Emergency Operations Plan. New hires receive education on the Emergency Operations Plan during the onboarding process. Additionally, staff were educated on all survey findings and corrective actions via email from the Quality Manager on 7/3/25. Compliance Monitoring Plan The Emergency Preparedness Coordinator will update the Emergency Agencies Contact List as changes to contacts become known. Furthermore, the Emergency Preparedness Coordinator will verify the accuracy of all contact information at least	

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			every two years as part of the required review of the Emergency Operations Plan. Finall,y, the Vice President of Nursing & Operations and Hospital President (who approve the Emergency Operations Plan every two years). can serve as an additional layer to ensure contacts for external resources remain a part of the plan in the future.	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct training for the Emergency Preparedness Program (EPP). *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and. This deficient practice could affect all staff and	E 0037	Organization Response: During review of the EP Training Program, the Emergency Preparedness Coordinator believed the surveyor was asking for documentation of "in-person training". Therefore, the Emergency Preparedness Coordinator's response that training had not been provided was correct based on their personal interpretation of the surveyor's question. The Conditions of Participation do not specify training on emergency preparedness policies and procedures must be conducted "in person", only that training and demonstration of knowledge needs to be provided every two years. The organization does provide training on the Emergency Operations Plan upon hire, and annually thereafter, as part of the	06/24/2025

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	patients in the facility. Findings include: Based on records review with the Emergency Preparedness Coordinator on 06/10/25 at 10:55 a.m., documentation of EEP initial training for new staff and training for existing staff every two years including demonstration of knowledge of the EPP was not available for review. Based on an interview at 11:50 a.m., the Emergency Preparedness Coordinator stated the EPP training for staff including demonstration of knowledge was not conducted within the last two years. This finding was reviewed with the President, Facilities Services Coordinator, Emergency Preparedness Coordinator, and Maintenance Tech II during the exit conference at 3:10 p.m.		mandatory computer-based learning modules all staff are required to complete. The module contains information on the key areas of mitigation/preparedness, response and recovery, and includes a mandatory quiz to validate staff understanding of the content. Staff must successfully complete computer-based learning modules by established deadlines or be subject to suspension from duties until successful completion is demonstrated. After review, all organizational staff completed the Emergency Operations Plan computer-based learning module in the fall of 2023, and again in the fall of 2024. Therefore the organization was in compliance with the Conditions of Participation at the time of survey. The 2025 annual education training window for all staff opens July 7, 2025 with a mandatory completion date of 10/1/2025. It has confirmed that the EPP is part of the assigned lessons again.	
K 0000 Bldg. 02	A Life Safety Code Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 485.623(c). Survey Date: 06/10/25 Facility Number: 005097	K 0000		

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	Provider Number: 151300 AIM Number: 100269320A At this Life Safety Code survey, Community Hospital of Bremen was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 485.623(c). Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). The Community Hospital of Bremen was built in 2006 and is a single-story fully sprinklered building of Type II (111) construction with a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility was surveyed with Chapter 19, Existing Health Care Occupancies of the Life Safety Code. The hospital provides overnight care, surgical services, and maintains an Emergency Department. The facility has 24 certified beds. At the time of the survey, the census was 7. Quality Review completed on 06/19/25			
K 0324 Bldg. 02	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to the designed and installed positions for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the	K 0324	Correction Activities: Maintenance Tech II purchased and installed Safety-Set Equipment Placement Systems for all appliances in the kitchen required to remain under the fire suppression system hood. The systems are installed directly into the floor, ensuring consistent placement of the appliance under	06/27/2025

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	fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affects staff, visitors, and patients in the cafeteria. Findings include: Based on observation with Maintenance Tech II on 06/10/25 at 1:20 p.m., the cooking equipment in the kitchen was covered by the fire suppression system, but the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on an interview at 1:20 p.m., Maintenance Tech II agreed the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. This finding was reviewed with the President, Facilities Services Coordinator, Emergency Preparedness Coordinator, and Maintenance Tech II during the exit conference at 3:10 p.m.		the hood after any movement for cleaning and maintenance. This work was completed on 7/02/25. Education: The Supervisor of Engineering educated the dietary staff and provided a standard work document on the use of the Safety-Set Equipment Placement System on 6/27/25. Additionally, all organization staff were educated on relevant survey findings and corrective actions via email from the Quality Manager on 7/3/25. Compliance Monitoring Plan: The Safety-Set Equipment Placement Systems are permanently installed to the floor, ensuring appliances are re-positioned under the hood each time they are moved for cleaning or maintenance. Users will enter Engineering work orders to initiate inspection and replacement, as necessary, should a system be found to have failed or not operate as intended.	

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K 0372 Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation, records review, and interview, the facility failed to ensure the penetrations caused by the passage of wires and/or conduits through 4 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier with a proper firestop system. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice could affect all occupants in the facility	K 0372	Correction Activities: The Facilities Services Coordinator directed that all penetrations in smoke walls identified during survey be sealed utilizing appropriately rated firestop material to meet ASTM E814 requirements. Additionally, the blue caulk observed in the lab smoke wall was removed and the penetration was sealed utilizing the appropriate firestop material. All work sealing the aforementioned penetrations was verified complete on 7/2/25. Education: The Facilities Services Coordinator developed a plan to remind contractors at the start of future projects on the importance of sealing penetrations in smoke walls utilizing appropriately rated firestop materials. As the Project Manager, the Facilities Services Coordinator will also ensure all penetrations have been appropriately addressed before final sing off of projects moving forward. Compliance Monitoring Plan: The project managers will follow up on all projects that require work to be performed above the ceiling to ensure that all penetrations have been sealed with appropriately rated firestop material.	07/02/2025

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	Findings include: Based on observation with the Facilities Services Coordinator and Maintenance Tech II on 06/10/25 between 2:10 p.m. and 2:30 p.m., the following smoke walls had unsealed penetrations or a firestop system not meeting ASTM E 814: a.) Above the ceiling tiles of the lab smoke wall, blue caulk with an ASTM listing was used to seal penetrations. b.) Above the ceiling tiles of the ER smoke wall contained two unsealed penetrations around conduits. c.) Above the ceiling tiles of the main hall smoke wall contained 10 unsealed screw size holes. d.) Above the ceiling tiles of the OB smoke wall contained an unsealed penetration around wires. Based on records review at 2:30 p.m., there was no documentation provided to show the firestop rating of the blue caulk. Based on interviews at 2:10 p.m. and 2:30 p.m., the Facilities Services Coordinator agreed there were smoke walls with unsealed penetrations and penetrations sealed with a blue caulk with an unknown ASTM listing. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m.			
K 0511 Bldg. 02	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 5 of 6 receptacles within 6 feet from a sink or located in a wet location were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment	K 0511	Correction Activities: An electrician was contracted and replaced all 5 receptacles with GFCI protected receptacles on 7/01/25. Education: The Quality Manager educated all	07/01/2025

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	to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could staff in the lab. Findings include: Based on observations with the Facilities Services Coordinator and Maintenance Tech II on 06/10/25 at 1:28 p.m., by each of the three work-sinks in the lab had two receptacles 3 feet from a water source. One receptacle was GFCI protected but the other five receptacles were not GFCI Protected. Based on an interview at 1:28 p.m., the Facilities Services Coordinator agreed there were receptacles by each work-sink in the lab that were not GFCI		staff on the survey findings and corrective actions via email on 7/3/25. Lab department staff were educated on 7/1 during the receptable replacement process. Compliance Monitoring Plan: The routine environment of care rounding process will be utilized to monitor for potential safety issues so that they can be evaluated and corrections made as necessary.	

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	protected. This finding was reviewed with the President, Facilities Services Coordinator, Emergency Preparedness Coordinator, and Maintenance Tech II during the exit conference at 3:10 p.m.			
K 0920 Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring including providing power to equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect all occupants in the main lobby. Findings include: Based on observations with Maintenance Tech II on 06/10/25 at 11:46 a.m. and at 1:18 p.m., a refrigerator and a microwave (high power draw equipment) were plugged into and supplied power by a power strip in the Anesthesia office, and an extension cord powered a radio in the Gift Shop. Based on interviews at 11:46 a.m. and 1:18 p.m., Maintenance Tech II agreed that a power strip was supplying power to high power draw equipment and an extension cord was powering a radio. This finding was reviewed with the President, Facilities Services Coordinator, Emergency Preparedness Coordinator, and Maintenance Tech II during the exit conference at 3:10 p.m.	K 0920	Correction Activities: The Engineering staff removed the power strip and extension cords from use on 6/11/25. Education: The Medical Staff utilizing the sleep rooms and the gift shop staff were educated on the expectation that power strips and extension cords are not to be used without the prior approval of the Engineering Department. Additionally, all staff were educated on all survey findings and corrective actions via email from the Quality Manager on 7/3/25 ensuring unauthorized use of power strips and extension cords does not reoccur in other areas of the organization. Surgical Manager also re-educated all medical staff who utilize the sleep rooms to not utilize power strips and extension cords without prior approval. Compliance Monitoring Plan: The routine environment of care rounding process will be utilized to monitor for potential safety issues so that they can be evaluated and	06/11/2025

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			corrections made as necessary.	
K 0923 Bldg. 02	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 1 of 1 piped oxygen storage room doors were provided with a precautionary sign stating "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING," that is readable from 5 feet. This deficient practice could affect staff by the oxygen storage room. Findings include: Based on observations with Maintenance Tech II on 06/10/25 at 1:00 p.m., the door to the main oxygen storage room containing piped oxygen tanks was not provided with a precautionary sign stating "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Based on an interview at 1:00 p.m., the Maintenance Director stated the door to the storage room was recently replaced and the new door was not provided with a precautionary sign that indicates storage of oxygen stating "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." This finding was reviewed with the President, Facilities Services Coordinator, Emergency Preparedness Coordinator, and Maintenance Tech II during the exit conference at 3:10 p.m.	K 0923	Correction Activities: A sign stating “DANGER: OXYGEN, NO SMOKING, NO OPEN FLAMES” was installed on the non-compliant door observed during the survey on 6/20/25. Education: The Quality Manager educated all staff on the survey findings and corrective actions via email on 7/3/25. Compliance Monitoring Plan: The routine environment of care rounding process will be utilized to monitor for potential safety issues, including the presence of safety related signage, so that corrections can be made as necessary in real time.	06/20/2025