STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151315	A. BUILDING 00 B. WING	05/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 0000 Bldg. 00	This visit was for a Critical Access Hospital re-certification survey and the OMNIBUS [COVID-19] Health Care Staff Vaccination survey in accordance with QSO-22-09-All Memorandum. Facility Number: 005037 Survey Date: 5/9-11/2022 and 6/13-14/2022 The OMNIBUS [COVID-19] Health Care Staff Vaccination survey in accordance with QSO-22-09-All Memorandum. The Indiana Department of Health has evaluated this facility and determined that it is in compliance with federal certification requirements. QA: 5/13/2022 and 6/20/22	C 0000		
C 0910 Bldg. 00	485.623 PHYSICAL PLANT AND ENVIRONMENT §485.623 Condition of Participation: Physical Plant and Environment Based on observation and interview, the facility failed to ensure 4 of 4 sliding ER corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke (see tag K363) and failed to ensure 1 of 3 electrical branches were not comingled (see tag K915). The cumulative effect of these systemic problems resulted in the facility's inability to ensure it had implemented a systemic plan of correction to prevent recurrence, therefore failing to ensure the provision of quality health care in a safe	C 0910	C- 910 **Tag K363 Corridor- Doors** **1. How Cameron corrected the deficiency:** A1 Door provided service to repair the latches of ER patient room doors 1, 2, 3, and 4 **(attachment 5- A1 Door work order, attachment 6- A1 Door Invoice)** **a. Date of correction:** 6/16/22 **b. Cameron reviewed all spaces in the facility that could be affected by the same**	06/16/2022

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

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	environment.		**deficient practice and changed practice:** · Will add door latch function checks to the Environment of Care Rounds Life Safety checklist for all clinical areas that have sliding patient room doors · The Environment of Care Compliance Coordinator will validate that all sliding patient room doors (ED (rooms 1-4), Pre-Post Surgery (rooms 1-12, 14), and Med-Surg (rooms 207 & 208)) latch into the frame, 100% of the time, when pushed closed **c. The steps Cameron will take to ensure the deficient practice does not recur:** · Vendor contract was signed for ongoing Preventative Maintenance and Inspection of manual sliding doors in Pre-Post surgery, Med Surg, and ED **(Attachment 7- A1 Preventative Maintenance and Inspection Agreement**, **attachment 8 - A 1 door Work order- PM June**) · Environment of Care Compliance Coordinator will document sliding patient room door latch function audit schedule and compliance rates on a Measures of Success Dashboard that will be shared in committees · The Plant Operations Executive Director reviewed the Environment of Care Tours Policy and will revise it to state: i. Add door	

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			latch function checks to the Environment of Care tour checklist ii. Environment of Care tours will occur with increased frequency, as needed, when a deficiency is identified, until sustained compliance is achieved iii. When a deficiency requires increased Environment of Care tour frequency, for compliance monitoring, compliance rates will be documented on the Measures of Success Dashboard that will be shared in committees **d. How Cameron will monitor the corrective actions, to ensure the deficient practice does not recur:** · The Environment of Care rounds monitoring, per the Environment of Care Compliance Coordinator, will occur weekly x 2, then monthly, until 100% compliance is achieved for 3 consecutive months. Compliance monitoring will then move to twice a year, per routine Environment of Care rounds schedule **Tag K 915 Electrical Systems-Essential Electric Systems** **1. How Cameron corrected the deficiency:** The breaker for the fire alarm panel was relocated to the Life Safety panel on the generator (**Attachment 1- LA**	

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			Electric- Fire alarm Control panel work order) **a. Date of correction:** 6/16/22 **b. Cameron reviewed all locations in the facility that could be affected by the same deficient practice and changed practice:** · Will add check of the breaker for the fire alarm panel, being connected to the Life Safety panel, to the Fire Alarm System Inspection and Testing Preventative Maintenance Agreement- inspections to be completed quarterly **c. The steps Cameron will take to ensure the deficient practice does not recur:** · The Plant Operations Executive Director reviewed the Fire Safety Management Plan and will revise it to add that the breaker for the fire alarm panel is located on the Life Safety panel, as per NFPA 99, 2012 edition · Environment of Care Compliance Coordinator will document the breaker inspection schedule and compliance rates on the Measures of Success Dashboard to be shared in committees **d. How Cameron will monitor the corrective action, to ensure the deficient practice does not recur:** · Compliance monitoring, per vendor, will be completed quarterly · These measures, along with	

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			any corrective action for deficiencies, will be reviewed by the Safety Committee, Quality and Patient Safety Committee, and the Board, until compliance is maintained for 12 months **2. 2. Who is responsible for # 1 above:** Plant Operations Executive Director **3. 3. If the deficiency is not yet corrected, by what date will Cameron have the deficiency corrected:** the deficiency has been corrected **1.**	
C 0914 Bldg. 00	485.623(b) , 485.623(b)(1) MAINTENANCE The CAH has housekeeping and preventive maintenance programs to ensure that-- (1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition; Based on observation and interview, the facility failed ensure 1 of 3 electrical branches were not comingled. NFPA 99, 2012 edition 6.5.2.2.2.1 states the life safety branch shall supply power for lighting, receptacles, and equipment as follows: (1) Illumination of means of egress in accordance with NFPA 101, Life Safety Code (2) Exit signs and exit directional signs in accordance with NFPA 101, Life Safety Code (3) Alarm and alerting systems, including the following:	C 0914	C 914 **Tag K 915 Electrical Systems-Essential Electric Systems** **1. 1. How Cameron corrected the deficiency:** The breaker for the fire alarm panel was relocated to the Life Safety panel on the generator (**Attachment 1- LA Electric- Fire alarm Control panel work order)**	06/16/2022

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	(a) Fire alarms. (b) Alarms required for systems used for the piping of nonflammable medical gases as specified in Chapter 5. (4) Communications systems, where used for issuing instructions during emergency conditions. (5) Sufficient lighting in dining and recreation areas to provide illumination to exit ways of a minimum of 5 ft-candles. (6) Task illumination and select receptacles at the generator set location. (7) Elevator cab lighting, control, communications, and signal systems. 6.5.2.2.2.2 states no functions, other than those listed in 6.5.2.2.2.1(1) through (7), shall be connected to the life safety. This deficient practice could affect all occupants. Finding include: Based on observation with the Facility's Director on 06/13/22 at 12:30 p.m. in the basement there was an electric panel identified as an equipment branch from the generator. The breaker for the fire alarm panel was located on this equipment panel instead of a life safety panel. Based on interview at the time of observation, the Facility's Director agreed the breaker for the fire alarm panel was located on an equipment panel and needs to be moved to a life safety panel. This finding was reviewed with the Safety Manager and Facility's Director during the exit conference.		**a. Date of correction:** 6/16/22 **b. Cameron reviewed all locations in the facility that could be affected by the same deficient practice and changed practice:** · Will add check of the breaker for the fire alarm panel, being connected to the Life Safety panel, to the Fire Alarm System Inspection and Testing Preventative Maintenance Agreement- inspections to be completed quarterly **c. The steps Cameron will take to ensure the deficient practice does not recur:** · The Plant Operations Executive Director reviewed the Fire Safety Management Plan and will revise it to add that the breaker for the fire alarm panel is located on the Life Safety panel, as per NFPA 99, 2012 edition · Environment of Care Compliance Coordinator will document the breaker inspection schedule and compliance rates on the Measures of Success Dashboard to be shared in committees **d. How Cameron will monitor the corrective action, to ensure the deficient practice does not recur:** · Compliance monitoring, per vendor, will be completed quarterly · These measures, along with any corrective action for deficiencies, will be reviewed by	

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			the Safety Committee, Quality and Patient Safety Committee, and the Board, until compliance is maintained for 12 months **2. Who is responsible for # 1 above:** Plant Operations Executive Director **3. If the deficiency is not yet corrected, by what date will Cameron have the deficiency corrected:** the deficiency has been corrected	
C 0930 Bldg. 00	485.623(c), 485.623(c)(1)(i) LIFE SAFETY FROM FIRE §485.623(c) Standard: Life Safety From Fire (1) Except as otherwise provided in this section: (i) The CAH must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) (ii) Notwithstanding paragraph (d)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors. Based on observation and interview, the facility failed to ensure 4 of 4 sliding ER corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 4 patients in the ER.	C 0930	Please consider this Plan of Correction to be Cameron Memorial Community Hospital's credible allegation of compliance C930 **Tag K363 Corridor- Doors** **1. How Cameron corrected**	06/14/2022

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	Findings include: Based on observation with the Facility's Director on 06/13/22 at 2:03 p.m., the sliding corridor doors to ER rooms 1, 2, 3, and 4 did not latch into the frame when evaluated. Based on interview at the time of observation, the Facility's Director stated the ER doors would not latch into the door frame because the latches were broken. This finding was reviewed with the Safety Manager and Facility's Director during the exit conference.		**the deficiency:** A1 Door provided service to repair the latches of ER patient room doors 1, 2, 3, and 4 **(attachment 5- A1 Door work order, attachment 6- A1 Door Invoice)** **a. Date of correction:** 6/14/22 **b. Cameron reviewed all spaces in the facility that could be affected by the same deficient practice and changed practice:** · Will add door latch function checks to the Environment of Care Rounds Life Safety checklist for all clinical areas that have sliding patient room doors · The Environment of Care Compliance Coordinator will validate that all sliding patient room doors (ED (rooms 1-4), Pre-Post Surgery (rooms 1-12, 14), and Med-Surg (rooms 207 & 208)) latch into the frame, 100% of the time, when pushed closed **c. The steps Cameron will take to ensure the deficient practice does not recur:** · Vendor contract was signed for ongoing Preventative Maintenance and Inspection of manual sliding doors in Pre-Post surgery, Med Surg, and ED **(Attachment 7- A1 Preventative Maintenance and Inspection Agreement**, **attachment 8 - A 1 door Work order- PM June**) · Environment of Care Compliance Coordinator will document sliding patient room	

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			door latch function audit schedule and compliance rates on a Measures of Success Dashboard to be shared in committees · The Plant Operations Executive Director reviewed the Environment of Care Tours Policy and will revise it to state: i. Add door latch function checks to the Environment of Care tour checklist ii. Environment of Care tours will occur with increased frequency, as needed, when a deficiency is identified, until sustained compliance is achieved iii. When a deficiency requires increased Environment of Care tour frequency, for compliance monitoring, compliance rates will be documented on the Measures of Success Dashboard to be shared in committees **d. How Cameron will monitor the corrective actions, to ensure the deficient practice does not recur:** · The Environment of Care rounds monitoring, per the Environment of Care Compliance Coordinator, will occur weekly x 2, then monthly, until 100% compliance is achieved for 3 consecutive months. Compliance monitoring will then move to twice	

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			a year, per routine Environment of Care rounds schedule · These measures, along with any corrective action for deficiencies, will be reviewed by the Safety Committee, Quality and Patient Safety Committee, and the Board, until compliance is maintained for 12 months 2. **Who is responsible for # 1 above:** Plant Operations Executive Director **3. If the deficiency is not yet corrected, by what date will Cameron have the deficiency corrected:** the deficiency has been corrected	
S 0000 Bldg. 00	This visit was for a State licensure survey of a Critical Access Hospital. Facility Number: 005037 Survey Date: 5/9/2022-5/11/2022 Cameron Memorial Community Hospital is in compliance with 410 IAC 15.1, Hospital Licensure Rules. QA: 5/13/2022	S 0000		