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	151300	A. BUILDING ______ B. WING ______	07/01/2021

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COMMUNITY HOSPITAL OF BREMEN INC	1020 HIGH RD BREMEN, IN 46506

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C 000	INITIAL COMMENTS This visit was for a Federal recertification survey and a Focused Infection Control Survey. Facility Number: 005097 Dates of Survey: 6/28/2021 to 7/1/2021 QA: 7/7/21	C 000		
C 910	PHYSICAL PLANT AND ENVIRONMENT CFR(s): 485.623 §485.623 Condition of Participation: Physical Plant and Environment This CONDITION is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 Hazardous room corridor doors in the EVS hall were not obstructed from closing. This deficient practice could affect staff in EVS hall (see K tag 321), failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2 (see K tag 711), failed to include all required information for 12 of 12 generator monthly load tests (see K tag 918), and failed to provide 1 of 1 established procedures for operating room emergencies (see K tag 933). The cumulative effect of these systemic problems resulted in the hospital's inability to ensure a safe environment was maintained to provide quality health care for patients.	C 910		9/15/21
C 930	LIFE SAFETY FROM FIRE CFR(s): 485.623(c), 485.623(c)(1)(i) §485.623(c) Standard: Life Safety From Fire (1) Except as otherwise provided in this section:	C 930		9/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		09/23/2021

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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C 930	Continued From page 1	C 930		

(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.
This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure 2 of 2 Hazardous room corridor doors in the EVS hall were not obstructed from closing, failed to provide 1 of 1 written emergency fire safety plan, and failed to provide 1 of 1 established procedures for operating room emergencies. .

Findings include:

1. Based on an observation during a tour of the facility with the Maintenance Mechanic and the Facilities Coordinator on 07/28/21 at 2:27 p.m., the EVS linen storage room and utility storage room contained combustible supplies, linen, and was greater than 50 square feet making this a hazardous area. The doors to the storage rooms were self-closing but the doors were propped open with a door wedge. Based on interview at the time of observation, the Facilities Coordinator agreed the storage rooms contained large amount of combustible storage, were larger than 50 square feet, and the corridor doors to the rooms were propped open.

2. This finding was reviewed with the

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C 930	Continued From page 2 Maintenance Mechanic, Facilities Coordinator, and the Director of Operations during the exit conference. 3. Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all patients, staff, and visitors in the event of an emergency. 4. Based on records review with the Facilities Coordinator and the Director of Operations on 07/28/21 at 10:37 a.m., the provided facility's fire safety plan did not address the following items: a) Extinguishment of fire. The fire safety plan did not indicate how use a fire extinguisher and did not address the types of fire extinguishers in the building. b) Evacuation of smoke compartment. The fire safety plan did not address partial evacuation by moving patients beyond a smoke or fire barrier. c) Emergency phone call to fire department. The facility did not address calling the fire department upon discover of a fire or activation of the fire alarm system. Based on interview at the time of record review, the Facilities Coordinator and Facilities Coordinator agreed the fire safety plan was	C 930		

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C 930	Continued From page 3 missing the aforementioned required information. 5. This finding was reviewed with the Maintenance Mechanic, Facilities Coordinator, and the Director of Operations during the exit conference. 6. Based on record review and interview, the facility failed to provide 1 of 1 established procedures for operating room emergencies. This deficient practice affects 2 patients using the operating rooms. 7. Based on records review with the Facilities Coordinator and the Lead O.R. Nurse on 07/28/21 at 4:01 p.m., the facility was unable to provide written procedures for operating room emergencies that includes alarm activation, evacuation, equipment shutdown, control operations, control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Based on interview at the time of observation, the Lead O.R. Nurse stated written procedures for operating room emergencies could not be located. 8. This finding was reviewed with the Maintenance Mechanic, Facilities Coordinator, and the Director of Operations during the exit conference.	C 930		
C 944	BUILDING SAFETY CFR(s): 485.623(d) Except as otherwise provided in this section, the CAH must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA	C 944		9/15/21

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C 944	Continued From page 4 12-5 and TIA 12-6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a CAH. (2) If application of the Health Care Facilities Code required under paragraph (e) of this section would result in unreasonable hardship for the CAH, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to include all required information for 12 of 12 generator monthly load tests. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Facilities Coordinator and the Maintenance Mechanic on 07/28/21 at 10:37 a.m., the monthly generator load test documentation failed to indicate the total time under load, cool down time, transfer time, and load percentage. Based on an interview at the time of record review, the Maintenance Director stated the load time is 45 minutes, cool down time is 15 minutes, transfer time is 2-3 seconds, and load percentage between 25% to 30%, but this information was not recorded on the monthly test form. This finding was reviewed with the Maintenance Mechanic, Facilities Coordinator, and the Director	C 944		

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C 944	Continued From page 5 of Operations during the exit conference.	C 944		
C1102	RECORDS SYSTEM CFR(s): 485.638(a)(1) (1) The CAH maintains a clinical records system in accordance with written policies and procedures. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure the anesthetist checked the anesthesia equipment prior to each administration of anesthesia in four (4) of five (5) anesthesia medical records (MR's) reviewed (Patient # 7, Patient # 17, Patient # 19 & Patient # 20). Findings include: 1. Review of the hospital policy titled "Adjunctive Life Support Equipment", policy number Surg.62, indicated it "is the responsibility of Anesthesia and/or Surgical Services personnel to verify that all equipment is available and in good working order. This policy was last revised in 06/2020. 2. Review of the "Rules And Regulations of The Medical Staff...", indicated on page six (6) that the anesthetist shall maintain a complete anesthesia record to include ... anesthesia equipment check. These regulations were last reviewed in 03/2021. 3. On 06/30/2021 at approximately 4:45 pm with administrative staff member A # 1 (Executive Director of Nursing), five (5) MR's were reviewed. Patient # 7, Patient # 17, Patient # 19 and Patient # 20's anesthesia records lacked documentation indicating the anesthesia equipment had been checked prior to the patient's procedure/surgery.	C1102		9/15/21

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C1102	Continued From page 6 4. In interview on 06/30/2021 at approximately 5:05 pm with administrative staff member A # 1, confirmed the anesthesia equipment should be checked prior to surgery.	C1102		
C1104	RECORDS SYSTEM CFR(s): 485.638(a)(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure the patient's medical record (MR) was accurately written and promptly completed for one (1) of two (2) swing bed patient's (Patient # 3), one (1) of three (3) acute care transfers (patient # 8), one (1) of three (3) death's (patient # 11) and four (4) of five (5) anesthesia medical records (MR's) reviewed (Patient # 7, Patient # 17, Patient # 19 & Patient # 20). Findings include: 1. Review of the hospital policy titled "Death of a Patient", policy number N075, indicated "an order to release the body is obtained from the physician". This policy was last revised in 03/2014. 2. Review of the hospital policy titled "Chart Completion Requirements/Documentation", policy number HIM073, indicated the attending practitioner shall be responsible for the medical portion of the record for each patient. The contents shall be pertinent and current. This policy was last revised on 04/27/2017.	C1104		9/15/21

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C1104	Continued From page 7	C1104		

3. Review of the hospital policy titled "Adjunctive Life Support Equipment", policy number Surg.62, indicated it "is the responsibility of Anesthesia and/or Surgical Services personnel to verify that all equipment is available and in good working order. This policy was last revised in 06/2020.

4. Review of the "Rules And Regulations of The Medical Staff...", indicated on page two (2) that all orders for treatment shall be entered into the electronic health record, the attending physician shall see that the MR "is complete", on page six (6) that the anesthetist shall maintain a complete anesthesia record to include ... anesthesia equipment check and on page seven (7) each patient's MR in the Emergency Department shall be signed by the practitioner in attendance who "is responsible for its clinical accuracy" These regulations were last reviewed in 03/2021.

5. On 06/29/2021 at approximately 10:15 am with administrative staff member A # 1 (Executive Director of Nursing), the MR for patient # 3 was reviewed. The MR lacked a consent to treatment signed by the swing bed patient and/or their healthcare representative. At 4:30 the MR for patient # 8 was reviewed. The MR indicated the patient had been transferred to an acute care hospital and also indicated the patient had been discharged home. At 5:30 pm the MR for patient # 11 was reviewed. The MR lacked a physician order to release the patient's body after death.

6. In interview on 06/29/2021 at approximately 10:20 am with administrative staff member A # 1, confirmed patient # 3's MR lacked a consent to treat. On 6/30/2021 at approximately 5:15 pm A # 1 confirmed the staff should have obtained a new

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C1104	Continued From page 8 signed consent to treat on the swing bed unit. 7. In interview on 06/29/2021 at approximately 4:30 pm with administrative staff member A # 1, confirmed the physician should have documented the correct location for discharge for patient # 8. 8. In interview on 06/29/2021 at approximately 5:13 pm with administrative staff member A # 1, confirmed the physician should have written the order to release the body of patient # 11.	C1104		
C1208	INFECTION PREVENT SURVEIL & CONTROL OF HAIs CFR(s): 485.640(a)(3) The infection prevention and control includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and that the program also addresses any infection control issues identified by public health authorities; and This STANDARD is not met as evidenced by: Based on document review, observation and interview the facility failed to follow their policy and procedure related to maintaining an environment that was clean/sanitary and disinfected in four (4) of five (5) units toured (Medical/Surgical/Swing Bed, Obstetrics, Nursery & Emergency Department). Findings include: 1. Review of the hospital policy titled, "Infection Prevention Program Plan", policy number IC, indicated the program goal was to decrease the risk of infection to patients, healthcare workers, and visitors by maintaining an environment that	C1208		9/15/21

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C1208	Continued From page 9	C1208		

"is clean and sanitary". This policy was last revised in 03/2021.

2. Review of the hospital policy titled, "Cleaning/Disinfection/Sterilization of Reusable Patient Care Equipment", policy number IC004, indicated that cleaning "is the removal of all visible dust". Reusable equipment "must be cleaned before" decontamination, "disinfection" or sterilization "can occur". The reusable equipment or item should be cleaned twice. The first cleaning cloth will remove visible soil; the second cleaning cloth will disinfect the equipment or item. This policy was last revised in 12/2020.

3. Review of the hospital policy titled, "Cleaning Procedures for Patient Rooms", policy number IC006, indicated to establish proper procedure to clean and prevent the transmission of diseases. Clean horizontal surfaces with cleaner and disinfectant. Clean and disinfect all bed and mattress surfaces with a clean cloth and cleaner disinfectant. This policy was last revised in 12/2020.

4. During the tour of the Medical/Surgical/Swing Bed unit on 06/29/2021 at approximately 8:40 am, with administrative staff member A # 1 (Executive Director of Nursing), the following was observed:
a. Visible wipeable dust on the isolation cart in room 112-A.
b. Visible wipeable dust on the horizontal edge of the window seal in the Sleep Lab room.
c. Visible wipeable dust on the bottom of the bed in Rooms 106 and 108.

5. During the tour of the Obstetric/Nursery unit on 06/29/2021 at approximately 11:00 am, with

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C1208	Continued From page 10	C1208		

administrative staff member A # 1, the following was observed:
a. Visible wipeable dust on base/bottom of the labor bed in suite LDRP-1 (Labor Delivery Recovery Postpartum).
b. Visible wipeable dust on the horizontal edge of the window seal in LDRP-1.
c. Visible wipeable dust on the back of the portable crib in LDRP-1.
d. Visible wipeable dust on the television stand in the Triage room.
e. Visible wipeable dust on the base/bottom of the patient cart in the Triage room.
f. Visible wipeable dust on the top of the lockers in the Triage room.
g. Visible wipeable dust on the baby warmer bottom base in the Nursery.
h. Visible wipeable dust on the horizontal edge of the window seal in the Nursery.

6. During the tour of the Emergency Department (ED) on 06/30/2021 at approximately 3:45 pm, with administrative staff member A # 1, the following was observed:
a. Visible wipeable dust on bottom/base of two (2) beds in the Trauma room.
b. Visible wipeable dust on the bottom storage shelf, top shelf where boxes of sutures were stored and inside six (6) clear containers holding finger splints in the Storage Utility room.

7. In interview on 06/29/2021 at approximately 10:00 am with A # 1, confirmed the areas observed above had visible wipeable dust.