

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAMERON MEMORIAL COMMUNITY HOSPITAL INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>416 E MAUMEE ST ANGOLA, IN 46703</b>		
(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	<p>INITIAL COMMENTS</p> <p>This visit was for a licensure review of negative pressure patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP.</p> <p>Facility Number: 005037</p> <p>Survey Date: 1/13/22</p> <p>The following patient rooms were successfully verified as negative pressure: Monoclonal Antibody Therapy Clinic, Room #1394.</p> <p>The following patient rooms failed to be successfully verified as negative pressure: None.</p> <p>QA: 1/21/2022</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE