STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150061		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING B. WING (X3) DATE SUR COMPLETE 06/26/201			ETED		
	PROVIDER OR SUPPLIEF			1314 E	ADDRESS, CITY, STATE, ZIP CODE WALNUT ST NGTON, IN 47501		
(X4) ID PREFIX TAG S000000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	one (1) State cor	•	S00	0000			
	Date of survey: 6-25-13 through 6/26/13						
	Facility number: 005056						
	•	per: IN00129632 efficiency related to					
	Surveyor: Jenni Public Health No	fer Hembree, RN urse Surveyor					
	QA: claughlin 08/1	5/13					
S000930	410 IAC 15-1.5-6 NURSING SERVI 410 IAC 15-1.5-6						
	(b) The nursing se following:	ervice shall have the					
	and evaluate the oprovided to each pased on docum interview, the reassure meals we medical record for	care planned for and coatient. ent review and staff gistered nurse failed to re documented in the for 4 of 5 closed medical d (patients #1-4), failed	S00	0930	#1,2,3,4,5,6,7,8,10,16,17 (nutr n and meal related) How: 1. Provided documentation education to all staff including physicians on proper documentaton of meals,	ritio	08/16/2013

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150061		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/26/2013		
	PROVIDER OR SUPPLIEF		1314 E	ADDRESS, CITY, STATE, ZIP COD WALNUT ST INGTON, IN 47501	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE ROPRIATE	(X5) COMPLETION DATE
	hair shampoo we patients (patients to ensure a famil of falls for 1 of 8 and failed to ensure a famil of falls for 1 of 8 and failed to ensure a famil of 8 patients (patients) weight loss and pof 8 patients (patients) for the family policy. "MEALS/SNAC reviewed/revised staff member monitored by unitary policy." The family policy is a family policy. The family policy is a family policy is a family policy. The family policy is a family policy is a family policy is a family policy. The family policy is a family policy is a family policy in the family policy. The family policy is a family policy is a family policy in the family policy is a family policy. The family policy is a family policy is a family policy in the family policy is a family policy policy in the family policy policy is a family policy po	ician of significant poor meal intake for 1 cient #2). : y titled KS" last 1 8/8/12 states: "5. The pointoring s patients mealtime and snack to percentage of food hed by each patient. od taken and fluid cumented into the comedical record for hack taken." y titled L ASSESSMENT AND viewed/revised 8/13/12 redure: "7. I and fluid intake is it staff and recorded flow sheet and recorded		supplements and snack. Added to weekly treatment meeting review of weight meal consumption at whice recommendations for diet changes and nutritional supplementation are made see attached revised intare output tab that now required meal consumed. All staff document into the electrorecord Prevent from record Prevent from Prev	nt team loss & ch time e. 3. ke and res % of nic ccurring: ng nd are notes chair rchased eview of o include ally for rent who on one on a ck is al onthly d shift ssion, ments. rector (bathing/ ff DL's by er than such as etup	

State Form Event ID: 3W2L11 Facility ID: 005056 If continuation sheet Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150061		LDING	onstruction 00	(X3) DATE (COMPL 06/26 /	ETED	
	ROVIDER OR SUPPLIER		1314 E	ADDRESS, CITY, STATE, ZIP CODE WALNUT ST NGTON, IN 47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated the foll (A) He/she was 4/19/13 and disc. (B) A problem was documentation of the medical record documentation of breakfast and lur were able to find amounts document worksheets on the worksheets are record. 4. Review of part indicated the foll (A) He/she was 4/22/13 and disc. (B) A problem was consumption in the record lacked meal consumption 5/7/13, 5/9/13, and able to find the recordings document worksheets are record. (at times bites for the patients) 5. Review of part indicated the foll 5. Review of part indicated the foll 6. Review of part indicated the foll 7. Review of part indicated the foll 8. Review of part indicated the foll 9. Review of part indicated the foll 1. Review of part indicated the foll	admitted to the BHU on harged on 5/9/13. was identified with f meal consumption in rd. The record lacked f consumption for each on 4/30/13. Staff the meal consumption ented on CNA daily e unit, however the not part of the medical tient #2 medical record owing: admitted to the BHU on harged on 5/16. was identified with meal the medical record documentation of on on 4/30/13, 5/2/13, and 5/12/13. Staff were meal consumption mented on CNA daily the unit, however the not part of the medical of there was a 0 or only ents intake).		daily updates given during shift report. 3. Review ADL needs during treatment to meetings on weekly basis. 4. Sattached ADL tab, all staff document into the electronic record Prevent from reoccurrin. Audit weekly documentation ADL's and provide feedback to staff and provide 1:1 educates as needed. Findings are discussed during monthly staff meetings. Responsible: Progr Director and Nurse Manager #10E, 16C, 16E,19 (Notification How: Re-educated staff to call physician and responsible party regarding falls and other unusual occurrences. Prevent from reoccurring: 1. Reviewing/auditing event documentation and providing feedback to individuals as needed, and discuss findings during staff meeting. Responsible: Nurse Manager	eam See ng: n of tion fram	
		admitted to the BHU on				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150061		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 06/26/2013			ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1314 E WALNUT ST WASHINGTON, IN 47501					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	(B) A problem of consumption in medical record I meal consumption 4/24/13, breakfa 4/25/13, lunch at breakfast, lunch lunch and dinner breakfast and lunwere able to find recordings docum worksheets on the worksheets are record. 6. Review of paindicated the fol (A) He/she was discharged on 5/(B) A problem of consumption in medical record I meal consumption in medical record I meal consumption in a dinner on 4/23/1 dinner on 4/25/1 4/26/13, breakfa 4/27/13 and 4/28 lunch on 4/30/13 find the meal condocumented on 0/25/14/26/13 find the meal condocumented on 0/25/14/26/14/	and dinner on 4/26/13, and dinner on 4/28/13, on 4/29/13, and inch on 4/30/13. Staff I the meal consumption mented on CNA daily including the unit, however the mot part of the medical distributed and the medical record distributed and the medical record. The acked documentation of on for breakfast and 3, breakfast, lunch and 3, breakfast and lunch inch and dinner on 3/13, and breakfast and 3. Staff were able to insumption recordings CNA daily worksheets ever the worksheets are						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 150061		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 06/26 /	ETED	
	PROVIDER OR SUPPLIER			1314 E V	DDRESS, CITY, STATE, ZIP CODE VALNUT ST IGTON, IN 47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	7. Staff member interviews condup.m. on 6/25/13 problem with medocumentation for	acted beginning at 3:40 that there was a eal consumption					
	a.m. on 6/26/13	#1 verified in acted beginning at 11:20 that there was a problem mption documentation					
	indicated the following (A) He/she was 4/19/13 and disc (B) A problem was no document received a bath of 4/30, 5/1, 5/3 and	admitted to the BHU on harged on 5/9/13. was identified with the hospital stay. There station that the patient for shower on 4/24, 4/29, d 5/6. There was only that it was documented					
	indicated the foll (A) He/she was 4/22/13 and disc (B) A problem was of physician noti had no meal inta occasions includ	admitted to the BHU on harged on 5/16/13. was identified with lack fication that the patient					

State Form Event ID: 3W2L11 Facility ID: 005056 If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150061		A. BUI	22) MULTIPLE CONSTRUCTION (X3) DATE SU BUILDING 00 COMPLET WING 06/26/20		ETED		
	PROVIDER OR SUPPLIER		1,	1314 E	DDRESS, CITY, STATE, ZIP CODE		
DAVIES	S COMMUNITY HO	SPITAL		WASHIN	NGTON, IN 47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and dinner on 5/ and dinner on 5/ lunch and dinner patient consume at lunch on 5/9/1 lunch on 5/12/13 (C) The dischar report was not ac dated 5/16/13 at "adequate Diet/I (D) The patient his/her stay. His was 167 pounds weight was 143. lacked documen was notified of t (E) The patient 8:30 p.m., on 4/3 on 5/1/13 at 6:35 lacked documen was notified. (F) A problem was bathing during th record lacked do or shower was ce through 5/1/13, 5/10/13, 5/10/13, 5/11/13 According to the patient did not he shampooed durin	ge nursing summary courate. The document 4:58 p.m. stated ciquid Intake". lost 23.4 pounds during wher admission weight and his/her discharge 60. The medical record tation that the physician he weight loss. had a fall on 4/28/13 at 80/13 at 7:10 a.m., and 5 p.m. The record tation that the spouse was identified with the hospital stay. The cumentation that a bath completed on 4/26/13 5/3/13, 5/6/13, 5/7/13, and 5/13/13. It medical record, the lave his/her hairing the visit.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI	
		150061	B. WING		06/26	/2013
NAME OF F	ROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				E WALNUT ST		
DAVIESS	S COMMUNITY HO	SPITAL	WASI	HINGTON, IN 47501		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	ROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	(A) He/she was	admitted to the BHU on				
	4/22/13 and disc	harged on 5/2/13.				
	(B) A problem v	was identified with				
	bathing during th	ne hospital stay. The				
	record lacked do	cumentation that the				
	patient received	a bath or shower on				
	•	, 4/29/13, and 5/1/13.				
	,	,				
	12. Review of patient #4 medical record					
	indicated the following:					
	(A) He/she was admitted on 4/22/13					
	and discharged on 5/1/13.					
	•	was identified with				
		ne hospital stay. The				
		cumentation that the				
	_	a bath or shower on				
	•	, 4/27/13, and 4/29/13.				
		ed documentation that				
	_	neir hair washed during				
	the stay.					
	_	atient #6 medical record				
	indicated the foll	lowing:				
	(A) He/she was	admitted to BHU on				
	6/21/13.					
	(B) A problem v	was identified with				
	bathing. The rec	ord lacked				
	documentation tl	hat the patient received				
	a bath or shower	-				
	6/24/13. The red	cord lacked				
		hat the patients hair				
	wash was washe	-				
	doi: do doi!e					
	14. Review of n	atient #7 medical record				
	l		1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION	150061		LDING	00	06/26/2	
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	.010
NAME OF I	PROVIDER OR SUPPLIEF	R			WALNUT ST		
DAVIES	S COMMUNITY HO	SPITAL			NGTON, IN 47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	Dirichi.e.i,	+	DATE
	indicated the following						
	(A) He/she was admitted to BHU on 6/17/13.						
		was identified with					
	bathing. The rec						
	_	hat the patient received					
		on 6/19/13, 6/21/13,					
	6/23/13, and 6/2						
		.,					
	15. Review of patient #8 medical record						
	indicated the following:						
		admitted to BHU on					
	6/21/13.						
	(B) A problem v	was identified with					
	bathing. The rec	ord lacked					
	documentation the	hat the patient received					
	a bath or shower	on 6/23/13 and					
	6/24/13.						
	16. Staff member	er #3 indicated the					
	following in inte	rviews conducted					
	beginning at 3:40	0 p.m. on 6/25/13:					
	(A) Nursing ass	istants give baths on the					
	=	the patient refuses. The					
	unit has a showe						
	` /	fied that the medical					
	records lacked d						
	_	and hair wash for the					
	medical records						
		fied that the spouse of					
	_	ot notified of falls.					
		fied that patient #2 had a					
	-	oor intake and there was					
no documentation that the physician was							

State Form Event ID: 3W2L11 Facility ID: 005056 If continuation sheet Page 8 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150061		A. BUILDING	LE CONSTRUCTION 00	COM	TE SURVEY MPLETED 26/2013	
	F PROVIDER OR SUPPLIER	<u> </u>	131	EET ADDRESS, CITY, STATE, 4 E WALNUT ST SHINGTON, IN 47501	, ZIP CODE	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFI	PROVIDER'S PLAN X (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION
TAG	notified or interver prior to 5/15/13. (E) When asked patient #2's falls notification, he/s should have been 17. Staff members, and partient #2 lad the physician was weight loss and his/her stay. He physician progrest treatment plan larelated to the polloss. 18. Facility pollicated to the polloss. 18. Facility pollicated (PATIEN GROOMING Noreviewed/revised policy: "In acconneeds and with compersonal hygienes taught as indicated particularly bath caring for hair and toilet." Under prestates: "2Patient with personal hygienes taught as indicated."	If the circumstances of would warrant family she indicated that family n notified. er #4 verified at 1:00 that the medical record exed documentation that as made aware of the poor intake during /she verified that the ess notes and the exceed information or intake and the weight acceptable with the executive of	TAG	i DEFICIEN	NCT)	DATE

State Form Event ID: 3W2L11 Facility ID: 005056 If continuation sheet Page 9 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2014 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 150061	A. BUILDING B. WING	00	COMPLETED 06/26/2013			
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
	S COMMUNITY HOS		1314 E WALNUT ST WASHINGTON, IN 47501					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Report Policy" la 7/12 states on parto be entered on trincludes (items we completed) and *Notification of stadministrator on-	sst reviewed/revised ge 3: "2. Information the Incident Report with * MUST be d page 4 states: "L.	IAU					

State Form Event ID: 3W2L11 Facility ID: 005056 If continuation sheet Page 10 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2014 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 150061	(X2) MULTIPLE CO A. BUILDING B. WING	00	COME	E SURVEY PLETED 6/2013		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP C WΔI NI IT ST	CODE			
DAVIESS	COMMUNITY HO	SPITAL	1314 E WALNUT ST WASHINGTON, IN 47501					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		

State Form Event ID: 3W2L11 Facility ID: 005056 If continuation sheet Page 11 of 11