STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			COMPLETED		
		150061	B. WING			04/11/2016	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			WALNUT ST		
DAVIESS	COMMUNITY HO	SPITAL			NGTON, IN 47501		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΤE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)			DEFICIENCY)		DATE
A 0000							
Bldg. 00	This visit was for a complaint.	or Federal investigation of	A 00	000			
	Complaint #IN0	0104606					
	•						
		a deficiency related to the					
	allegations is cit	ted.					
	Dates of Survey: 4/11-12/16						
	Dutes of Survey	. 1/11 12/10					
	Facility Number: 005056 QA: cjl 04/18/16						
A 0837 Bldg. 00	along with necess	REFERRAL t transfer or refer patients, sary medical information, to ies, agencies, or outpatient led, for follow-up or					
	Based on docum interview, the ho necessary medic receiving facility	nent review and ospital failed to transfer cal information to a y for 1 of 10 patient (P1) (MR) reviewed.	A 08	337	A-0837 How: A discharge checklist ha been built in the electronic medical record, which includes list of required items that are to accompany the patient upon discharge, which also includes documentation box for addition	s a o	05/10/2016

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.

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			00	COMPLETED	
	150061		B. W.	ING		04/11/	2016
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					WALNUT ST		
DAVIESS COMMUNITY HOSPITAL				WASHI	NGTON, IN 47501		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	,	tia	DATE
	1 5 . 0.1	1			pertinent information or educa sent with the patient. A copy of		
		e policy titled Transfer of			the new tab is attached to this	, ,	
	· ·	ility and intra-facility			response. Staff were also ask		
	indicated the fol	•			to review the "Transfer of Patie	ent,	
		fer of the patient will be			Inter-facility and Intra-facility" policy requirements, along with the new "Discharge to"		
		hysician based on					
		treatment and/or			documentation tab.		
	services.						
		elines for Transfer of					
	Patient to Nursing Home: 5. A completed transfer form, summary of care record,				Prevent from reoccurring:		
					r revent from reoccurring.		
	and medication i	reconciliation					
	sheetmust be s	ent with the patient. 7.					
	The following m	nust accompany the		Periodic review of medical records for documentation			
	patient: c. H&P	(history and physical); e.			compliance and providing		
	Other pertinent i	nformation.		feedback to individuals as needed.			
	c. The p	olicy was reviewed					
	3/2015.						
	2. Review of P1	's MR indicated the		Responsible: VP of Nursing		nd	
	following:				Nurse Managers		
	a. The p	atient was admitted to the					
	hospital's BHU (behavioral health unit)					
	on 2/2/16. On 2	/10/16, the patient					
	experienced a fa	ll resulting in hip					
	fracture, was tra	nsferred to a					
	medical/surgical	unit and underwent hip					
	surgery on 2/11/	16.					
		/16/16 a PEG					
	(percutaneous er	ndoscopic gastrostomy)					
	~	ally placed for nutritional					
	enteral feedings.						
	_	Discharge					
		nmary Report indicated					
	1						

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
	150061		B. W	ING		04/11/	2016
VIAC OF DECAME OF A STREET				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1314 E	WALNUT ST		
	S COMMUNITY HO	SPITAL		WASHII	NGTON, IN 47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF COL			(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)			COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		:47hrs, the patient was					
		SNF, the CDA (clinical					
		architecture) was sent and					
	report was called	d to the receiving nurse at					
	the SNF.						
	d. The N	MR lacked documentation					
	of an H&P or fe	eding tube					
	orders/instructio	ns being sent/provided to					
	the SNF.						
	3. On 4/12/16 a	t 10:15am, A5, RN					
	(registered nurse)/Quality PI (performance improvement), indicated it						
	~	ermined from the MR for					
	P1 that the H&P						
		e sent or provided to the					
	SNF.	e sent of provided to the					
	SINF.						
	4. On 4/12/16 a	t 12:00pm, A2,					
	Quality/Infection	n Prevention Manager,					
	indicated the CD	OA is pulled from a Quick					
		list within the MR.					
		I the list to include the					
	following: Hosp						
		al History, Problems,					
		lergies, Results, Vital					
	Signs, Plan of C						
		nunizations, Functional					
	•	· ·					
	Status and Hosp	nai Discharge					
	Instructions.						
	5. Review of the	e printed CDA document					
	of P1 lacked doo	cumentation of an H&P					
	and lacked documentation of feeding type						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MZS811 Facility ID: 005056

If continuation sheet Page 3 of 7

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 150061	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/11/2016				
	ROVIDER OR SUPPLIER COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 E WALNUT ST WASHINGTON, IN 47501						
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
S 0000	or feeding tube instructions.							
Bldg. 00	Bldg. 00 This visit was for State investigation of a complaint.							
	Complaint #IN00194606 Substantiated; a deficiency related to the allegations is cited.							
	Dates of Survey: 4/11-12/16							
	Facility Number: 005056							
	QA: cjl 04/18/16							
S 0912 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)							
	(iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:							

State Form Event ID: MZS811 Facility ID: 005056 If continuation sheet Page 4 of 7

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLET			ETED		
	150061		B. WING			04/11/2016		
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 E WALNUT ST WASHINGTON, IN 47501					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	nursing personnel to provide care for areas of the hospi (ii) Maintaining a descriptions with responsibilities for positions. (iv) Ensuring that a personnel meet ar requirements as e hospital and medic procedure, and fer requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements as endospital and medical procedure, and ferrometers. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements. (v) Establishing the nursing care and personnel meet ar requirements as endospital and medical procedure, and ferrometers are also and meet ar requirements as endospital and meet ar requirements as endospital and medical procedure, and ferrometers are also and meet ar requirements as endospital and medical procedure, and ferrometers are also and meet ar requirements as endospital and medical procedure, and ferrometers are also and meet ar requirements as endospital and meet ar requirements as	r the following: of the services, limited to, pes and numbers of and staff necessary r all patient care tal. current nursing on chart. urrent job reporting r all nursing staff all nursing nnual in-service established by cal staff policy and deral and state e standards of oractice in all nursing care is spital. tent review and urse executive failed to atients (P1) was cordance with policy and e policy titled Transfer of cility and intra-facility	S 09	012	S-0912 How: A discharge checklist hat been built in the electronic medical record, which includes list of required items that are to accompany the patient upon discharge, which also includes documentation box for addition pertinent information or educated sent with the patient. A copy of the new tab is attached to this response. Staff were also ask to review the "Transfer of Patie Inter-facility and Intra-facility" policy requirements, along with the new "Discharge to" documentation tab.	s a o nal tion of ed ent,	05/10/2016	

State Form Event ID: MZS811 Facility ID: 005056 If continuation sheet Page 5 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150061		(X2) MULT A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 04/11 /	ETED		
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 E WALNUT ST WASHINGTON, IN 47501					
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
Patient to Nursing transfer form, surfansfer form, surfand medication resheetmust be seen and medication resheetmust be seen and medication resheetmust be seen and medication respectively. The following material respectively. 2. Review of P1' following: a. The pathospital's BHU (It on 2/2/16. On 2/2 experienced a fall fracture, was transmedical/surgical surgery on 2/11/1 b. On 2/1 (percutaneous en tube was surgical enteral feedings. c. The Done is a seen and medical feedings.	ent with the patient. 7. ust accompany the history and physical); e. nformation. blicy was reviewed Is MR indicated the atient was admitted to the behavioral health unit) 10/16, the patient 1 resulting in hip asferred to a unit and underwent hip 16. 16/16 a PEG doscopic gastrostomy) Ily placed for nutritional ischarge mary Report indicated 47hrs, the patient was NF, the CDA (clinical rehitecture) was sent and to the receiving nurse at IR lacked documentation			Prevent from reoccurring: Periodic review of medical records for documentation compliance and providing feedback to individuals as needed. Responsible: VP of Nursing ar Nurse Managers	nd			

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

PRINTED: 05/13/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150061			ILDING	00	COMPL 04/11/	ETED		
NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 E WALNUT ST WASHINGTON, IN 47501					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			TE	(X5) COMPLETION DATE	
	orders/instruction the SNF.	ns being sent/provided to						
	(registered nurse (performance im could not be dete P1 that the H&P	aprovement), indicated it ermined from the MR for						
	indicated the CE Links selection I He/she indicated following: Hosp Diagnosis, Socia Medications, Al Signs, Plan of C Encounters, Imn Status and Hosp Instructions.	n Prevention Manager, DA is pulled from a Quick ist within the MR. I the list to include the bital Admission Il History, Problems, lergies, Results, Vital are, Procedures, nunizations, Functional ital Discharge						
	of P1 lacked doc	e printed CDA document cumentation of an H&P mentation of feeding type instructions.						

State Form Event ID: MZS811 Facility ID: 005056 If continuation sheet Page 7 of 7