

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/04/2024
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 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 the investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00403697 - No deficiency related to the allegation is cited.</p> <p>Survey Date: 01/04/2024</p> <p>Facility Number: 005056</p> <p>Daviess Community Hospital is in compliance with 410 IAC 15-1.6-2 Emergency Services, Hospital Licensure Rules in regard to the investigation of complaint IN00403697.</p> <p>QA: 1/24/2024 & 1/25/2024</p>	S 000		

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

TITLE

(X6) DATE