STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
S000000		S000000		
	This visit was for a State hospital licensure survey. Dates: 3/10/2014 through 3/11/2014 Facility Number: 005056 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Jennifer Hembree, RN PH Nurse Surveyor Ken Ziegler Medical Surveyor			
S000322	QA: claughlin 03/26/14 410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and staff	S000322	All departments organization wide will ensure that their policies and plans are current and updated	10/01/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	interview, the facility failed to ensure 5 departmental policies were reviewed at least triennially: Nutritional Services, Nursing Administration, Environmental Services, Infection Control, and Maintenance Department. Findings included: 1. Daviess Community Hospital Organizational Manual Initiation/Reviewing/Revising of Policies (last revised 6/12) states, "Departmental manuals are to be updated with current policies and procedures, minimally on a three year basis." 2. The following department policies were reviewed: Nutritional Services, Nursing Administration, Environmental Services, Infection Control, and Maintenance Department. At least 12 Nutritional Service policies were not reviewed triennially. At least 60 Nursing Administration policies were not reviewed triennially. At least 275 Environmental Service policies were not reviewed triennially. At least 9 Infection Control policies were not reviewed triennially. At least 51 Maintenance Service policies were not reviewed triennially. 3. At 12:00 PM on 3/10/2014, staff member #1 confirmed over 60 nursing policies were not reviewed triennially. The staff member indicated every hospital department was not reviewing all their policies triennially. 4. At 1:15 PM on 3/11/2014, staff member #4 indicated the Nutritional Service policies were only reviewed by the Dietician and the Foodservice Supervisor and not by Quality Council as required.		within the next six months. The Fire and Safety Plan will be taken to the next Quality Council, which is scheduled on May 6, 2014 for review and approval. Once policies and plans are current and updated they will be reviewed and approved through the Quality Council at a minimum of triennially. The Director of Regulatory Compliance or her designee will monitor the progress on the updating of the policies and plans every 30 days during the next six months to ensure progress is being made and the task will be completed organization wide within the six month period. All department managers will be responsible for ensuring the policies and plans for their respective departments are current and updated on an ongoing basis. The Director of Regulatory Compliance or her designee will be responsible for monitoring ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
S000406	5. At 2:45 PM on 3/11/2014, staff member #6 indicated the Maintenance Department policy and procedure manual was missing and the manual policies were not on the Internet. The staff member indicated he/she has been writing new policies and procedures for the Maintenance Department, however, none of the policies have been approved by the Quality Council. The Fire Plan and Safety Plan have never been approved by the Quality Council. 410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and staff interview, the facility failed to ensure four services, Housekeeping, Inpatient Rehab, Cardiac Rehab, and Behavioral Health Unit were part of its comprehensive quality assessment and improvement (QA&I) program. Findings included: 1. Daviess Community Hospital, 2012 - 2013 Performance Improvement Plan implements	S000406	The hospital will have a comprehensive Quality Assessment and Improvement (QA&I) Program in which all areas of the hospital will participate. These areas will include all services, including Housekeeping, Inpatient Rehab, Cardiac Rehab, Behavioral Health and those furnished by a contractor. The Quality Manager or her designee will ensure all services with direct or indirect impact on patient care quality will	05/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. 2. The Quality Performance Improvement minutes and departmental data evidenced that four services, Housekeeping, Inpatient Rehab, Cardiac Rehab, and Behavioral Health Unit were not monitored and evaluated as part of the hospitals comprehensive quality assessment and improvement (QA&I) program. 3. At 3:15 PM on 2/10/2014, staff member #2 confirmed the four services were not being monitored or evaluated by the Quality Council or the Department itself.		be reviewed under the quality improvement program. All services will also be monitored by the Quality Council. The Quality Manager will be responsible for ongoing compliance.	
S000554	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, the facility failed to provide an environment that minimized risk to patients on 2 of 6 units toured. Findings include; 1. During tour of the Emergency Department beginning at 2:50 p.m. on 3/10/14 the ENT cart was observed with most of the contents expired including, but not limited to, nine (9) boxes of nasal packing expiring 1/11 through 1/14 and one (1) box of nasal dressing expiring 8/13. 2. During tour of the Medical Surgical unit	S000554	The outdated contents of the ENT cart in the Emergency Department were removed immediately on 3/10/14. The pitcher and spoon were thrown away immediately on 3/10/14. The Emergency Department has implemented a monthly check for the prevention of outdates on all carts, containers, bins, etc containing dated supply items. The Emergency Department Manager or her designee will be responsible for ongoing monitoring. The hospital has a monthly Environmental of	03/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	beginning at 4:00 p.m. on 3/10/14 a large plastic spoon and plastic pitcher with writing indicating it was used to "mix bowel prep" was stored under a soiled handwashing sink.		Care Rounds that is completed by each department. That form includes ensuring there is no storage under the sinks. These are completed monthly by the department managers or their designee. The department managers will be responsible for ongoing compliance of no storage under the sinks.The Director of Regulatory Compliance or her designee will have the responsibility for monitoring the ongoing compliance.	
S000592	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (i) Sanitation. Based on document review, observation, and interview, the facility failed to ensure cleaning policies were followed on the Behavioral Health Unit (BHU). Findings include;	S000592	On 3/11/14 the shower room was cleaned using a hospital approved disinfectant and all unapproved cleaners were removed from the cleaning closet. An inservice has been completed on 3/19/14 for the BHU staff by the department manager on the proper cleaning	03/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	1. Facility policy titled "SHOWER AND TUB ROOM USE" last reviewed/revised 8/6/12 states under procedure: "4. After the patient has completed a shower in communal facilities, the shower is to be cleaned after each use with a hospital approved disinfectant." 2. Review of labels for GP forward and Crew cleaner indicated the cleaners are not a disinfectant. 3. During tour of the BHU beginning at 9:25 a.m. on 3/11/14, the following was observed in the shower room: (A) Dried brown substance smeared on the back side of the seat on the shower chair. (B) Powder on the floor under the shower chair. 4. NA #1 indicated the following in interview at the time of tour: (A) The shower room had not been used on day shift and had been cleaned by night shift after use. (B) He/she uses GP Forward and Crew Cleaner to clean in the shower when he/she uses it.		of the shower and tub room according to the hospital policy and procedure and the correct disinfectant to use. The BHU Manager or his designee will do routine spot checks at a minimum of weekly of the shower room and the cleaning of it by staff to ensure ongoing compliance. The Infection Control Manager or her designee will also do monthly surveillance of units for cleanliness and approved cleaners, which will be reported at the bi-monthly infection control meeting.	
S000610	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on document review and observation, the facility failed to date mark or discard expired food items on 2 of 6 units toured. Findings include; 1. Facility policy titled "FOOD STORAGE" last reviewed/revised 12/08 states on page 1: "Leftover foods are covered, dated, and labeled with the date of expiration or storage date clearly noted on the label....." 2. During tour of the BHU beginning at 9:25 a.m. on 3/11/14 the following was observed: (A) An opened package of ham slices was observed in the patient refrigerator on the East wing. The package was not covered, dated, or labeled according to policy. (B) Three (3) cartons of fat free milk with an expiration date of 3/10/14 was observed in the patient refrigerator on the East wing. (C) A large package of ham labled and dated with an expiration date of 3/9/14 was observed in the patient refrigerator on the	S000610	All items identified in the regrigerators on BHU and in the ICU were removed and disposed of on 3/10/14 and 3/11/14. All unopened food kept in refrigerators will have an expiration date. All leftover food will be covered, dated, and labeled with the date of expiration or storage date clearly noted on the label.Refrigerators will be checked daily by department staff and food will be removed as necessary. Department Managers or their designee will be responsible for ongoing compliance. The Infection Control Manager or her designee will also do monthly surveillance of units for cleanliness of refrigerators, proper storage and proper labeling of food items, which will be reported at the bi-monthly Infection Control Meeting.	03/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	West wing. 3. During tour of the Intensive Care unit (ICU) beginning at 3:00 p.m. on 3/10/14 an opened container of chicken broth marked as opened on 3/6/14 was observed in the patient refrigerator. The container did not contain an expiration date.			
S000612	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (xi) A program of linen management for personnel involved in linen handling. Based on document review, observation and interview, the facility failed to ensure laundry services were provided according to facility policy for 1 in-house laundry service on the Rehab unit and failed to develop a policy for laundry services for 1 in-house laundry service on the Behavioral Health unit (BHU). Findings include; 1. Facility policy titled "Infection Control- ADL Washer and Dryer" last reviewed/revised 1/13/14 states under policy "The washer and	S000612	A new facility policy is being written for all washers and dryers in patient care areas. The hospital is also contracting with Ecolab to provide disinfectant processes which meet CDC and CMS guidelines for infection control in linen/laundry management. Staff will be inserviced on the new policy and procedure. Department managers, along with the Infection Control Manager or her designee, will be responsible for random spot checking at a	05/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	dryer shall be used by the rehabilitation unit staff for training purposes and for cleaning rehabilitation patient personal clothing." and under procedures, the policy states "Disinfectant shall be used with each load of laundry." 2. The above policy was posted on the wall by the washer and dryer on the Rehab unit. There was no disinfectant in the laundry closet nor did the detergent available contain a disinfectant. 3. CNA #1 indicated in interview at 10:30 a.m. on 3/11/14 that he/she uses Purex detergent and dryer sheets to wash laundry on the unit. 4. Staff member #2 indicated in interview at 2:25 p.m. on 3/11/14 that there was no policy for laundry services for the BHU.		minimum of weekly to ensure ongoing compliance.	
S000930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and staff interview, the facility failed to ensure a registered nurse followed physician orders related to wound assessments for 2 of 3 patients on the Rehabilitation (Rehab) unit. Findings include; 1. Review of patient #16 medical record	S000930	All patients will have a Registered Nurse supervise and evaluate the care planned for and provided. All medical records shall include documentation that all orders for patients are being followed. Twenty four hour chart checks will be completed by the department nurses to ensure orders are being implemented and documented. Department Nurse Managers or	05/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	indicated an order was written on 10/10/13 for nursing to remove boot every shift for skin assessment. The medical record lacked documentation that the order was followed. 2. Review of patient #22 medical record indicated an order was written on 10/22/13 for nursing to remove the ace wrap every shift and check for skin breakdown. The medical record lacked documentation that the order was followed. 3. Staff member #2 verified the above at 4:15 p.m. on 3/11/14.		their designee will perform random spot checks at a minimum of monthly of medical record documentation. The Director of Regulatory Compliance or her designee will have the responsibility for monitoring the ongoing compliance.	
S000932	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. Based on document review, the facility failed to ensure care plans were individualized for 3 of 8 care plans reviewed. Findings include; 1. Facility policy titled "Care Planning" last reviewed/revised 11/10 states on page 1 under policy: "An individualized plan of care must be in place for all patients outside of the Emergency Department....." 2. Review of patients #1, 11, and 15 medical records indicated the care plans were not individualized for the patients. The staff had	S000932	An individualized plan of care will be developed and in place for all patients being cared for outside of the Emergency Department. Department nurses will implement the electronic care plan and will also individualize the care plan for each patient on admission. Care plans will be checked and updated during each twenty four hour chart check as needed. Random chart checks will be performed at a minimum of monthly by the department manager or her designee.The Director of Regulatory Compliance or her designee will	05/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	not removed areas that were not pertinent to the patient from the electronic care plan.		have the responsibility for monitoring the ongoing compliance.	
S001024	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction. Based on observation and interview, the facility failed to ensure expired intravenous solutions (IV) were removed from patient stock for 4 of 6 units toured and failed to remove unusable medications from stock for 1 surgery department toured. Findings include; 1. During facility tour beginning at 1:55 p.m. the following observations were made: (A) One (1) bag of Plasma-lyte with an expiration date of Jan 2014, five (5) bags of 5% Dextrose with expiration dates of Dec 2012, Nov 2012, July 2013, Aug 2013, and Oct 2013 were observed in the anesthesia work room within the Surgery Department. (B) One opened and partially used vial of	S001024	All expired or unusable solutions/medications were immediately removed from stock on 3/10/14 and 3/11/14. Materials Management personnel are now checking all department main supply areas at a minimum of monthly for upcoming expiration dates. Department Managers or their designee are checking other supply areas in all depts for upcoming expiration dates at a minimum of monthly. The Surgical Services Director or her designee will spot check the anesthesia carts at least weekly to ensure correct labeling, upcoming outdates, of any vials or syringes. One on one education was also done with all	05/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	Succinycholine was observed in the anesthesia cart drawer. The vial was not dated as to when it was opened. Additionally, there was a syringe drawn up with a clear solution marked as Succinycholine observed in the anesthesia cart. Both were in a non-refrigerated area. (C) Two (2) bags of 5% .2 % Sodium Chloride with an expiration date of February 2014, one (1) bag of 5% .9 % Sodium Chloride with an expiration date of January 2014, one (1) bag of .9% Sodium Chloride with an expiration date of February 2014, and two (2) bags of 5% .2% Sodium Chloride with an expiration date of February 2014 and two (2) bags of 5% .45 % Sodium Chloride with an expiration date of January 2014 were observed in the medication room on the Medical/Surgical floor. (D) One (1) bag of Lactated Ringers with an expiration date of November 2013 was observed in the medication room in the Intensive Care unit. (E) One (1) bag of 5% .45 % Dextrose with an expiration date of March 1, 2014 in the clean utility room within the Emergency Department. 2. Staff member #NN1 (surgery manager) indicated in interview at time of tour that the Succinylcholine was stable for 2 weeks out of the refrigerator.		the anesthesia providers and this was completed on 3/20/14. The Director of Regulatory Compliance or her designee will have the responsibility for monitoring the ongoing compliance.	
S001118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in two (2) instances: Boiler Room and Housekeeping Storage/Laundry. Findings included: 1. At 3:10 PM on 3/11/2014, the Environmental Service Department was toured. All electrical control panels were observed obstructed by housekeeping carts, wire carts, housekeeping supplies. The large room's floor was heavily caked with loose trash and debris. The elevator access panel was obstructed by 4 wired storage racks. The wired racks were filled with loose housekeeping and maintenance supplies. The Environmental service storage and laundry room was cluttered with all types of materials. 2. At 3:35 PM on 3/11/2014, the Boiler Room was toured. The room's floor was heavily cluttered with leaves, loose paper, maintenance equipment, and other debris. The room was observed with empty skids standing upward throughout the Boiler Room. 3. At 4:00 PM on 3/10/2014, staff member #6 confirmed the Boiler Room and the Environmental Storage and Laundry Room were very cluttered and needed to be	S001118	On 3/11/14 the obstructed electrical control panel and the elevator access panel were cleared. The floor that was littered with leaves, paper and other debris have been cleared. The environmental storage and laundry room have been cleaned and organized. The boiler room has also been cleaned and the skids have been removed. These areas will be cleaned and maintained on a routine basis. These areas will be spot checked by the Housekeeping Manager, the Director of Environmental Services or their designees for ongoing compliance. The Infection Control Manager or her designee will also do monthly surveillance for cleanliness of the environmental service storage and laundry area and the boiler room, which will be reported at the bi-monthly Infection Control Meeting.	05/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
S001160	cleaned up. 410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1) (d) The equipment requirements are as follows: (1) All equipment shall be in good working order and regularly serviced and maintained. Based on documentation review and staff interview, the hospital failed to comply with Surgery Department's Operating Room's humidity 30-60%humidity range for three Operating Rooms. Findings Included: 1. Daviess Community Hospital Surgical Services Safety (Last approved 1/12) states, "The humidity of each O.R. will be maintained at 30 to 60 percent." 2. The hospital has 4 operating rooms; however, Operating Room #1 was utilized for storage of equipment and was not used for an operating room. Surgery Daily Temperature and Humidity Logs were reviewed from 1/2/2014 to 3/10/2014. Operating Room #2 humidity level was less than the required 30 percent 39 of 47 days that the humidity levels were recorded. Operating Room #3 humidity level was less than the required 30 percent 45 of 47 days that the humidity levels were recorded. Operating Room #4 humidity level was less than the required 30 percent 37 of 47 days that the humidity levels were recorded.	S001160	The policy Surgical Service Safety has been changed to state that the humidity of each O.R. will be maintained at 20 to 60 percent as allowed by the CMS Life Safety Code waiver permitting new and existing ventilation systems supplying hospital anesthetizing locations to operate with a relative humidity of greater than or equal to 20 percent instead of 35 percent. The humdity of each O.R. is checked daily. Humidity level will continue to be monitored by the Surgery Staff and any reading out of range will be reported to the Maintenance Department. Humidification equipment to correct the humidity has been approved for purchase by Administration and has been ordered. The equipment should be delivered and installed within the next eight weeks. The Director of Regulatory Compliance will monitor to ensure the equipment is installed in the specified time frame. Humidities will continue to be monitored daily. The Director of Regulatory	06/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	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) COMPLETION DATE
	3. At 3:15 PM on 3/10/2014, staff member #6 confirmed the humidity levels are not between 30 and 60 percent most of the time. The Maintenance Department was aware of the issue and are working on it.		Compliance or her designee will have the responsibility for monitoring the ongoing compliance.	