STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005056	A. BUILDING: _____ B. WING _____	05/17/2017

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) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one State hospital complaint investigation. Complaint number: IN00216721 Unsubstantiated: lack of sufficient evidence. Survey date: 5/17/17 Facility Number: 005056 Daviess Community Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.6-4, Psychiatric Services, Hospital Licensure Rules. QA: 9/18/17	S 000		