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

PRINTED: 04/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE

(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
G 000	INITIAL COMMENTS A partial extended survey for Medicare certification to [ ] was completed on 03/16/12. Ten home visits were completed and a total of twenty clinical records were reviewed.	G 000		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on review of clinical records and agency policy [ ] failed to assure the 60-day summary to the physician contained clinical findings, facts about care furnished, and progress toward goals pertinent to the patient's diagnosis and status in four of five applicable records (Records/Patients #4, #10, #13, and #15). Findings are: Policy No: 3-005.1 Ongoing Communication, 60-day Summary/Progress Summary stated in part: The purpose of the policy stated: "To define the process for documenting patient/caregiver progress and demonstrating interdisciplinary communication in the clinical record." The policy portion stated in part: "The 60-Day Summary will be completed on all patients during the recertification period. The case manager completes the summary. The summary reflects the care provided by all disciplines as well as demonstrated interdisciplinary communications." RECORD/PATIENT #4: The 60-day summary documented for the	G 145	Please See Attached	

Please See Attached by each Tag Cited

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

Sign and Date

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

For example if page 1 of 33 you will need to send in all 33 pages

FEDERAL PLAN OF CORRECTION

Provider/Supplier Name:	Oldtown Community Hospital		Survey Date
STREET ADDRESS, CITY, ZIP:	321 Main Street, Oldtown 66600		05/21/2009
		(X1) PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER	26-XXXX

Type Name , Address, Survey Date

Type Provider #

(X4) ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [illegible]CH CORRECTIVE ACTION SHOULD BE CROSS-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A043	Keys were hung on 5/11/09; however, the locks were then removed from the obstetrics department. The Maintenance Supervisor will conduct inspections to ensure that locks are not replaced. The Safety Committee Chairperson will also conduct inspections to verify the locks have not been replaced. The Board will continue to conduct quarterly inspections of the facility.	05/22/2009
A144	Education will be provided to staff members will include Policy #2009-12, Decubitus U[illegible] Prevention. See attached Policy #2009-12. Patients admitting with risk under "skin" [illegible] an airmattress applied. Patients admitting with risk of pressure sores who are unabl[illegible] [illegible]ition themselves will be placed on turning schedule. The Charge Nurse will moni[illegible] [illegible]ts admitted during shift for any infectious processes and will initiate the appropriate [illegible]cautions to control the spread of infection.Each Med/Surge nurse will be responsible to monitor the Turn Schedule Sheet during their shift, asassessments warrant.TheMed/SurgManager will be responsible for monitoring patients with risk under"skin"or pressure sores.The Chief Nursing Officer will ensure appropriate precautions are taken by monitoring activity.	05/22/2009

Type Plan of Correction

Type Tag Cited

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

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Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE

(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
G 000	484.10 Initial Comments A partial extended survey for state licensure for ______ was completed on 03/16/12. Ten home visits were completed and a total of twenty clinical records were reviewed.	G 000		
G545	484.14(g) Coordination of Patient Services A written summary report for each patient is sent to the attending physician at least every 62 days. This regulation is not met as evidenced by: REFER TO FEDERAL TAG G145.	G545		
G558	484.18 Acceptance of Patients, POC, Med Supervision Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This regulation is not met as evidenced by: REFER TO FEDERAL TAG G158.	G558		
G559	484.18(a) Plan of Care The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This regulation is not met as evidenced by: REFER TO FEDERAL TAG G159.	G559		
G572	484.30(a) Duties of the Registered Nurse	G572		

Missouri Department of Health and Senior Services

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

STATE FORM

Please See Attached by each Tag

Sign and Date

For example if page 1 of 3 you will need to send in all 3 pages

STATE PLAN OF CORRECTION

Provider/Supplier Name:	Oldtown Community Hospital	Survey Date
STREET ADDRESS, CITY, ZIP:	321 Main Street, Oldtown 66600	05/21/2009
	(X1) PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER	26-XXXX

(X4) ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CROSS-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A043	REFER TO FEDERAL TAG	05/22/2009
A144	Refer to Federal Tag	05/22/2009

Type Name , Address, Survey Date

Type Provider #

Type Tag Cited

Type Refer to Federal Tag unless the tag was not cited as a Federal

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