i ´		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 152027	A. BUILDING B. WING	00	COMPLETED	
132021		_		03/07/2018		
	PROVIDER OR SUPPLIE OSPITAL OF FOR		2200 F	ADDRESS, CITY, STATE, ZIP CODE IANDALLIA DRIVE 5TH FLOOR WAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	T	(V5)	
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL SELSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
A 0000	REGULATORTOR	TESC IDENTIFICATION (NOT CREATED IN)	ind		DATE	
DI-I 00						
Bldg. 00	Federal hospital	•	A 0000			
	Complaint Num	ber: IN00253605				
	Substantiated: Deficiency related to the allegations is cited. Unrelated deficiencies cited.					
	Survey Date: 3/	6-7/18				
	Facility Number	:: 012132				
	QA: 3/22/18					
A 0117 Bldg. 00	A hospital must in appropriate, the pallowed under Starights, in advance	S: NOTICE OF RIGHTS  Iform each patient, or when latient's representative (as late law), of the patient's lof furnishing or lent care whenever				
	Based on docum interview, the fa Notice of Patien each patient or t	cility failed to ensure the t Rights was provided to heir representative for 2 ords (MR) reviewed	A 0117	A-117 The Admissions department reviewed process regarding Admission paperwork internally and with nursing. Nursing is responsible for Inpatient consent and DNR, Admissions Case Management is responsible for Patient		

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.

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		î ´	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 03/07/	ETED	
	PROVIDER OR SUPPLIER			2200 RA	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Admission Proceed indicated the following elements in the aninclude provide admissions documented in the necessory required Inpatient are iii. Patient in Responsibilities.  2. Review of the Acknowledgemed Care Information lacked document of the Patient Righad been provided representative an obtained by a factory. MR for Patients documentation in Patient Rights are provided and significant of registration.	mentation package to the gal representative and sary signatures The at Admissions Forms Rights and"  MR document titled ent of Receipt of Health a for Patients #2 and #6 tation indicating a copy ghts and Responsibilities ed to the patient or their ad signature of receipt cility staff.  1430 hours, the Chief staff A3 confirmed the #2 and #6 lacked adicating the notice of ad Responsibilities was nature obtained at the on.			Rights and Responsibilities.  Prevent: Admissions department to revidally for completion of admissionsent documentation.  Responsible Party: Admission Manager  Goal: 100% completion of admission paperwork within 48 hours and reviewed for 3 months  Audit results will be reported to QAPI, MEC and Governing Bocommittees.  Expected date of completion is: 03/19/18	on d d oard	
A 0286 Bldg. 00	limited to, an ongo	(					

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

Event ID:

7MO511 Facility ID: 012132

If continuation sheet

Page 2 of 10

		X1) PROVIDER/SUPPLIER/CLIA	ĺ		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPLE	
		152027	B. WI			03/07/2	2018
NAME OF F	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR	,	
VIBRA H	OSPITAL OF FOR	Γ WAYNE			WAYNE, IN 46805	•	
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG	which there is evident and reduce medic (2) The hospital medical trackadverse particularly (2) Performance must track medical patient events, an implement prevent mechanisms that learning througho (e) Executive Resign governing body (c) individual who assand responsibility hospital), medical officials are responsuring the follow (3) That clear expessablished. Based on docum interview, the farm policy/procedure reviewing an advort 7 patient events and the follow (5) The follow (6) The follow (7) patient events are employees through the follow (8) The follow (9) The follow (1) Review of the follow (1) Review of the follow (2) The following and the follow (3) The following and the following are the following and the following are the follo	dence that it will identify all errors. aust measure, analyze, and atient events ties improvement activities all errors and adverse alyze their causes, and tive actions and include feedback and ut the hospital.  ponsibilities, The hospital's or organized group or sumes full legal authority for operations of the staff, and administrative ansible and accountable for wing: pectations for safety are tent review and cility failed to follow its es for documenting and everse patient event for 1 ats (Patient #1) reviewed.  Example 2.16 Illuming: "All unusual to be reported by gh the online reporting	A 02		A-286 1. The Director of Quality and Risk Management re-educated the Leadership Team during QAP regarding patient incident entrinto Q-solutions.  2. Instructions on Q-solution e provided to the Leadership teat 3. Q-solutions incident Reporting reviewed with leadership.  Prevent Reoccurrence: Direct of Quality educated leadership team at monthly QAPI meeting Q-solutions power point sent of the providence o	entry am.	03/19/2018
	occurrence repor	rt must be completed				_	

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

Event ID:

7MO511 Facility ID: 012132

If continuation sheet Page 3 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		152027	B. W	ING		03/07/	2018
	.n.o.vvnnn o	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		2200 R	ANDALLIA DRIVE 5TH FLOOR		
	OSPITAL OF FORT			FORT V	VAYNE, IN 46805		
(X4) ID		TATEMENT 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 APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
		ves a patient, objective			to nursing supervisors and department leaders to review	with	
		ions and actions taken			their staff on 2/22/2018.	vvitii	
	are precisely doc	cumented in the medical					
	record"				Goal:		
					100% review of Q-solutions		
	2. Review of the	e MR for Patient #1 on			incidents		
		the patient reported not			reported with unusual		
		nd was observed to be			occurrences for 3 months. Audit results will be		
	lethargic, drowsy				reported to		
	"	of the day. The MR			QAPI, MEC and Governing Bo	oard	
		_					
	_	ient was observed by			Responsible Party:		
		Nurse, staff N11 and			Chief Clinical Officer		
		eral occasions by the			Expected date of completion		
	1	for a change in status			<b>is:</b> 03/19/18		
	before Narcan (n	naloxone) was			03/19/16		
	administered by	IV route with immediate					
	arousal and agita	ation noted.					
	3. Review of inc	cident reports for the					
	period around 2-	5-18 failed to indicate an					
	event involving l	Patient #1.					
	4. On 3-7-18 at	1115 hours, the Director					
		aff A7 confirmed that no					
		lent or ADR (adverse					
		ion) of the event on					
		Patient #1 had been					
	_						
	submitted or revi	ieweu.					
	5 On 2 7 10 -4	1420 hours the Chief					
		1430 hours, the Chief					
		staff A3 confirmed that					
		rt documentation for the					
	event involving	Patient #1 was available.					
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		152027	B. W				018
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ANDALLIA DRIVE 5TH FLOOR		
VIBRA H	OSPITAL OF FORT	WAYNE			WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
A 0395 Bldg. 00	A registered nurse evaluate the nursi	N OF NURSING CARE must supervise and ng care for each patient.		• • •			
	-	iment review and	A 0	395	A-395		03/07/2018
	interview, the Re	egistered Nurse failed to			Nursing staff educated on documentation for all patient		
	supervise and ev	aluate the care provided			care including condition change	ies	
	to each patient for	or 1 of 9 medical records				,00.	
	(MR) reviewed (	Patient #1).			2. Documentation should be		
	Findings include	:			current and reflect all care provided to patients	,	
	1 Review of the	e policy/procedure			Prevent Reoccurrence:		
	Medical Records				HIM and Nursing Leadership		
		evised 12-16) indicated			review clinical documentation		
		*			monthly. Clinical audits		
	_	All medical records will			began on February 1, 2018.		
		ntation to substantiate			Responsible Party:		
	care and treatme	nt provided."			Chief Clinical Officer		
	2. Review of the	e MR for Patient #1			Goal:		
	indicated the foll	owing orders on 1-20-18			100% documentation of workli	st	
	at 2100 hours: "	alternate foot drop boot			orders. Reviewed for 3 months	3.	
	every two hours.	•			Audit	.	
	J 37-20				results will be reported to QAF	′1,	
	3 Review of the	e MR for Patient #1			MEC and Governing Board		
		tation indicating the foot			committees.		
		moved from one foot					
	•				Responsible Party:		
	•	e alternate foot every two			Chief Clinical Officer		
	hours.				Expected date of completion		
					is: 03/07/18		
		1430 hours, the Chief			03/07/10		
	Clinical Officer,	staff A3 confirmed the					
	MR lacked docu	mentation indicating the					
	foot drop boot w	as removed and replaced					

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

Event ID:

7MO511 Facility ID: 012132

If continuation sheet Page 5 of 10

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  152027		A. BUILDING 00 COMPLETED  B. WING 03/07/2018				
NAME OF PROVIDER OR SUPPLIER  VIBRA HOSPITAL OF FORT WAYNE			2200 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
S 0000	as ordered.					
Bldg. 00	State hospital co	Deficiency related to the ed. Unrelated d.	S 0000			
S 0102 Bldg. 00	all applicable fede local laws and rule Based on docum interview, the fac Notice of Patient each patient or the	rall be licensed by d shall comply with ral, state, and es. ent review and cility failed to ensure the Rights was provided to neir representative for 2 ords (MR) reviewed	S 0102	1 3.  The Admissions department reviewed process regarding dmission paperwork internally and with nursing. Nursing is responsible for Inpatient consent and DNR		

State Form Event ID: 7MO511 Facility ID: 012132 If continuation sheet Page 6 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 152027	A. BUILDING 00 COMPLETED  B. WING 03/07/2018					
		152027	D. W		_	03/07/	2018	
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE			
VIBRA H	OSPITAL OF FORT	Γ.W.ΔΥΝΕ			ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805			
					. I VVATINE, IN 40805			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE	
	Findings include	,			Admissions or Case Managem	nent	5.112	
	1 manigs merade	··			is responsible for Patient Righ			
	1 Review of the	e policy/procedure			and Responsibilities.			
		ess (revised 2-18)						
		lowing: "The essential						
		admissions process			Prevent Reoccurrence:			
	include provid	•			Admissions department to revi			
	•	mentation package to the			daily for completion of admissi consent documentation.	on		
		gal representative and			Responsible Party:			
		sary signaturesThe			Admission Manager			
		nt Admissions Forms			Monitoring:			
	are iii. Patient				# of Patients with correct	_		
	Responsibilities.	· ·			admission paperwork completon including Patient Rights/ # of	5		
	responsionnes.	•••			patients in admitted to the			
	2 Review of the	e MR document titled			hospital			
		ent of Receipt of Health			Goal:			
	_	n for Patients #2 and #6			100% completion of admission	1		
		tation indicating a copy			paperwork within 48 hours and			
		ghts and Responsibilities			reviewed for for 3 month. Audi			
		ed to the patient or their			results will be reported to QAF	l,		
	•	nd signature of receipt			MEC and Governing Board committees.			
	obtained by a fac							
	ootamed by a fac	cinty starr.						
	3 On 3-7-18 at	1430 hours, the Chief						
		staff A3 confirmed the						
		#2 and #6 lacked						
		ndicating the notice of						
		nd Responsibilities was						
	_	gnature obtained at the						
	time of registrati							
	01 1081011111							
S 0418	410 IAC 15-1.4-2							
DI4~ 00	QUALITY ASSES IMPROVEMENT	SMENT AND						
Bldg. 00	410 IAC 15-1.4-2(	(b)(1)(2)						
	i '		1				i	

State Form Event ID: 7MO511 Facility ID: 012132 If continuation sheet Page 7 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET				
		152027	B. WING 03/07/2018				2018
NAME OF PROVIDER OR SUPPLIER  VIBRA HOSPITAL OF FORT WAYNE			2200 R/ FORT V	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
	through the quality improvement programment programmen	to address the improvement found assessment and gram as follows:  If the action shall be its effectiveness, ap and impact on the improvement for 1 and the improvement event for 1 and improvement event event event event event for 1 and improvement event eve	S 04	418	1. The Director of Quality and Risk Management re-educated the Leadership Team during QAPI regarding patient incider entry into Q-solutions. 2. Instructions on Q-solution entry into Q-solutions incident reporting reviewed with leadership.  Prevent Reoccurrence: Director of Quality educated leadership team at monthly QA meeting in January and Februa Q-solutions power point sent to nursing supervisors and department leaders to review their staff on 2/22/2018.  Responsible Party: Chief Clinical Officer Monitoring: # of Patients with unusual occurrences documented in Q-solutions / # of unusual occurrences reported Goal: 100% review of Q-solutions incidents reported with	ntry nm. API ary. out	03/08/2018
	2 5 10 maicaica	the patient reported not			unusual occurrences for 3		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  152027		A. BUILDING B. WING	00	COMPLETED 03/07/2018	
	ROVIDER OR SUPPLIER		2200 F	ADDRESS, CITY, STATE, ZIP CO RANDALLIA DRIVE 5TH F WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
	feeling "right" ar lethargic, drowsy significant part of indicated the pat their Registered evaluated on sev Physician MD11 before Narcan (nadministered by arousal and agita 3. Review of inception around 2-event involving but the second of the period around 2-event involving but the second of the period around 2-event involving submitted or review. 5. On 3-7-18 at Clinical Officer, no incident report	and was observed to be and pale for a soft the day. The MR ient was observed by Nurse, staff N11 and eral occasions by the for a change in status saloxone) was IV route with immediate attion noted.  Eident reports for the 5-18 failed to indicate an Patient #1.  1115 hours, the Director off A7 confirmed that no ent or ADR (adverse ion) of the event on patient #1 had been		months. Audit results reported to QAPI, MEC Governing Board	will be
S 0930	410 IAC 15-1.5-6 NURSING SERVI	CE			
Bldg. 00	following:	rvice shall have the urse shall supervise			

State Form Event ID: 7MO511 Facility ID: 012132 If continuation sheet Page 9 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		152027	B. WING 03/07/20			/2018	
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ANDALLIA DRIVE 5TH FLOOR		
VIRRA H	OSPITAL OF FORT	Γ WAYNE			NAYNE, IN 46805		
					, in 40000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	provided to each	care planned for and					
	I .	ument review and	S 09	030	Nursing staff educated on		03/08/2018
	_		30	750	documentation for all patient of	are	03/08/2018
	· ·	egistered Nurse failed to			including condition changes.		
	-	valuate the care provided			2 4. Documentation should be	ре	
	_	or 1 of 9 medical records			current and reflect all care		
	(MR) reviewed (	(Patient #1).			provided to patients.		
					Prevent Reoccurrence:		
	Findings include	e:			HIM and Nursing Leadership review clinical documentatio		
					monthly. Clinical audits bega		
	1. Review of the	e policy/procedure			on February 1, 2018.	411	
		s Documentation			, , , , , , , , , , , , , , , , , , , ,		
		evised 12-16) indicated			Responsible Party:		
		All medical records will			Chief Clinical Officer		
	_	ntation to substantiate					
					Monitoring:		
	care and treatme	ent provided."			# of orders with correct		
					nursing documentation / # of orders on worklist		
		e MR for Patient #1			Goal:		
		lowing orders on 1-20-18			100% documentation of		
	at 2100 hours: "	alternate foot drop boot			worklist orders. Reviewed fo	r 3	
	every two hours.	."			months. Audit results will be	!	
					reported to QAPI, MEC and		
	3. Review of the	e MR for Patient #1			Governing Board committees	s.	
	lacked documen	tation indicating the foot					
		emoved from one foot					
		e alternate foot every two					
	hours.	a minimum root overy two					
	nours.						
	1 On 2 7 10 -4	1420 hours the Chief					
		1430 hours, the Chief					
		staff A3 confirmed the					
		mentation indicating the					
	_	as removed and replaced					
	as ordered.						

State Form Event ID: 7MO511 Facility ID: 012132 If continuation sheet Page 10 of 10