	R MEDICARE & MEDI			ONGTRUCTION	OMB NO. 0938-	-0391
	NT OF DEFICIENCIES				(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	152027	B. WING	00	03/14/2018	
		102021			00/14/2010	
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE RANDALLIA DRIVE 5TH FLO	סר	
VIBRA H	OSPITAL OF FOR	T WAYNE		WAYNE, IN 46805	JK	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMDUCT	ΓΙΟΝ
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	]
0000						
Bldg. 00						
		a follow up survey of one	A 0000	The following plan of correct		
	· · · ·	nmediate Jeopardy (IJ)		intended to demonstrate the	e	
		conducted on $2/14/18$ . The		facility's commitment to		
	Immediate Jeopard	dy was removed.		compliance with applicable		
		- D100254140		and federal regulations. The statements set forth below		
	Complaint Numbe	r: 11NUU254140		not be construed as an adr		
	Date: 3/14/18			or constitute agreement wit		
	Date. 5/14/18			deficiencies alleged. The fa		
	Facility Number:	012132		has taken or will take the a		
	racinty runioer.	012152		set forth in the following pla	n of	
	QA: 3/22/18			correction by the dates indi	cated.	
A 0115	482.13					
	PATIENT RIGHT	S				
Bldg. 00	A hospital must p	protect and promote each				
	patient's rights.					
			A 0115	New attending group starte		201
	Based on document review and interview the			3/8/18 and implemented da	lly	
		nsure restraints were		rounding with clinical team members.		
		e earliest time possible for 2 of at medical records reviewed of		During rounding, patient		
		ts. (see tag 154), failed to		assessments are complete	d and	
	-	ation of the patient's plan of		an assessment of the need		
		straint for 1 of 2 (#3) patient		continue or discontinue res	traints	
		viewed of patients in restraint.		is reviewed.		
		ed to document the appropriate		Justification of restraint nee		
		nent of restraint implemented		reviewed and documented	daily	
	according to facili	ty policy and procedure for 2 of		on Restraint Flow Sheet.		
		nt medical records reviewed of		Prevent Reoccurrence:	· Shift	
		ts. (see tag 167), failed to		Immediate Process change huddles conducted to revie		
		as written by a physician or		Restraint Policy and Flow s		
		ependent practitioner prior to		documentation. Day shift		
		s for 1 of 2 (#3) patient medical		nursewill implement Restra	int	
		of patients in restraints. (see tag		FlowSheet during daily clin		
		ure the attending physician was t use for 2 of 2 (#2 and 3)		rounding. New order obtain		
		cords reviewed of patients in		placed on nursing work list	to	
	patient medical le	lorus reviewed of patients III		notify nurse of every 2hour		

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

TITLE

(X6) DATE

PRINTED:

07/20/2018

Any defiencystatement 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.

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		152027	B. WING		03/14/	2018
NAME OF 1	PROVIDER OR SUPPLIE	P	STREET	ADDRESS, CITY, STATE, ZIP CODE		
				RANDALLIA DRIVE 5TH FLOOF	R	
VIBRA H	OSPITAL OF FOR	TWAYNE	FORT	WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		170), failed to ensure physician		rounding requirement. A post		
		e duration and/or a time limit $f_{abc} = 2 a f_{abc}^{2} (\# 2 a + 2)$ matient		restraint assessment will be conducted during daily clinica	1	
		for 2 of 2 (#2 and 3) patient		rounding following all	I	
		viewed of patients in restraints. d to ensure after 24 hours that a		initialrestraint orders. This rev	iew	
		ment by the physician or		will include the type and		
		ent practitioner (LIP) was done		placement of restraints.		
	· · · ·	ew order for restraint for 2 of 2		Person Responsible:		
		medical records reviewed of		Chief Clinical Officer		
	· · ·	ts. (see tag 172), failed to		Monitoring:		
	· ·	on of the patient who is		# of completed restraint		
	restrained is monit	ored according to intervals		flowsheet / # of patients with	ו	
	determined by hos	pital policy for 2 of 2 (#2 and		restraints		
	3) patient medical	records reviewed of patients in		Goal:		
		175), and failed to document		100% completion of restrain	t	
		nued use for restraints for 2 of 2		flowsheet for 3 consecutive	4.	
		medical records reviewed of		months. Outcomes reported QAPI,MEC &GB.	το	
	patients in restrain	ts. (see tag 188)		QAFI, WIEC & GD.		
	The cumulative ef	fect of these systemic problems				
		pital's inability to ensure that				
	Patients Rights we	-				
A 0154	482.13(e)					
- 01J <del>4</del>	( )	AINT OR SECLUSION				
Bldg. 00		estraint or Seclusion. All				
g. 00	•	right to be free from				
		al abuse, and corporal				
		patients have the right to be				
		t or seclusion, of any form,				
		ans of coercion, discipline,				
		retaliation by staff.				
		usion may only be imposed				
		nediate physical safety of ff member, or others and				
		nued at the earliest possible				
	time.					
		nt review and interview the	A 0154	1. Daily clinical rounding is		03/15/202
		sure restraints were		completed to review the need	to	03/13/20
				continue or		

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	ECTION IDENTIFICATION NUMBER: A. BUILDING 00		00	COMPLETED	
	152027		B. WING		03/14/2018	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	CR	2200 F	ANDALLIA DRIVE 5TH FLOOR		
/IBRA H	IOSPITAL OF FOR	RT WAYNE	FORT	WAYNE, IN 46805		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	2 (#2 and 3) patier	nt medical records reviewed of		discontinue restraint use. If		
	patients in restrain	ts.		restraints are discontinued, ar	n	
				order is written		
	Findings:			during rounding.		
				2. A. Daily review of		
	1. Policy titled, "I	Restraint Use",		documentation to be complete	ed	
	revised/reapprove	d 2/18, indicated on pg. 3, point		prior to the end of shift by		
		is made to remove the patient		staff nurse and nurse supervis		
		oon as possibleIf the		B. a. through f. Physician daily	/	
		discontinue the restraint order		rounding discusses		
		ion, a discontinue order must be		discontinuation of restraints.		
	written."			Order is documented in the El		
				and on the Restraint flow shee		
	2. Review of patie	ent medical records on 3/14/18		3. Education to staff on restra	nt	
	-	317 hours indicated, patient:		discontinuation reviewed with		
		Order and Flow Record,		staff		
		6/18 indicated patient was in		educator.		
		s x2 and physician order was		Prevent Reoccurrence:		
		rs. There was no documentation		Shift supervisor will review all		
		e every 2 hours, so it cannot be		sheets for currently restrained		
		ong the patient was in restraints.		patients of required	a.m.t	
		xed documentation of		documentation. This assessm	ent	
	discontinuation or			will determined to continue or discontinue restraint use. New		
		Order and Flow Record,		order to continue or discontinu		
	Medical, dated:			will be completed during daily		
	· · · ·	ated patient was in soft limb		clinical rounding with physicia	n	
		0700 hours to 0659 hours. The		Responsible Party:		
	flowsheet lacked d			Chief Clinical Officer		
	discontinuation or			Monitoring:		
		ated patient was in soft limb		# of completed restraint 2 ho	ur	
		2200 hours to 0659 hours. The		documentation per shift / # c		
	flowsheet lacked d			restraint patients with review		
		der of restraint for time period		100% patients in restraints		
		100 hours when patient was not		Goal:		
	in restraints.	nears men parent was not		100% Compliance for the 3		
		ted patient was in soft limb		consecutive months.		
		0700 hours to 0450 hours. The		consecutive months.		
	flowsheet lacked of					
		der of restraint for time period				
		244 hours when patient was not				
	in restraints.	2 nours when patient was not				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 152027 B. WING 03/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 RANDALLIA DRIVE 5TH FLOOR VIBRA HOSPITAL OF FORT WAYNE FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG d. 3/6/18 indicated patient was in soft limb restraint x1 from 0700 hours to 1800 hours. The flowsheet lacked documentation of discontinuation order of restraint for time period of 1900 hours to 0659 hours when patient was not in restraints. e. 3/10/18 indicated patient was in soft limb restraints x2 from 1920 hours to 0538 hours. The flowsheet lacked documentation of discontinuation order of restraint for time period of 0700 hours to 1919 hours when patient was not in restraints. f. 3/12/18 indicated patient was in soft limb restraint x1 from 0700 hours to 1300 hours. The flowsheet lacked documentation of discontinuation order of restraint for time period of 1301 hours to 0659 hours. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records. Medical. lacked documentation of a discontinuation order of restraint as required per policy and procedure. A 0166 482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION Bldg. 00 The use of restraint or seclusion must be--(i) in accordance with a written modification to the patient's plan of care. Based on document review and interview, the A 0166 1. - 3. Reviewed Restraint Care 03/15/2018 facility failed to ensure the modification of the Plan documentation with clinical staff patient's plan of care with use of restraint for 1 of beginning on 2/15/2018 and 2 (#3) patient medical records reviewed of refresher review March 15, 2018 patients in restraint. April 6, 2018. **Prevent Reoccurrence:** Findings: Staff nurse to review patient care plans regarding restraints 1. Policy titled, "Restraint Use", dailyand update care plan revised/reapproved 2/18, indicated on pg. 3, point FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **TR3F12** Facility ID: 012132 If continuation sheet Page 4 of 24

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07/20/2018

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED
		152027	152027 B. WING		03/14/2018
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
VIBRA H	IOSPITAL OF FOR	T WAYNE		RANDALLIA DRIVE 5TH FLOOI WAYNE, IN 46805	R
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETIO
TAG	<ul> <li>8., "Documentatio initiated, and throu use and will initiat Plan: Risk for Inju</li> <li>2. Review of patie at approximately 1 #3's, Restraint Ord dated 3/5/18 that p x1 from 0800 hour lacked documentation of care on the a.m.</li> <li>3. Staff 8 (Nurse 1 3/14/18 at approxi confirmed the aboo and Flow Records documentation of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statem</li></ul>	ent medical records on 3/14/18 317 hours indicated on patient er and Flow Record, Medical, atient was in soft limb restraint rs to 0500 hours. The flowsheet tion of modification of the plan shift. Manager) was interviewed on mately 1339 hours, and we-mentioned Restraint Order	TAG	accordingly. Responsible Party: Chief Clinical Officer Monitoring: # of Patients with correct ca plan regarding restraints / # patients in restraints Goal: 100% completion of restraint care plan document in HMS for 3 month. Audit results will be reported to QAPI, MEC and Governing Board committees.	are ¢ of
A 0167 Bidg. 00	SECLUSION [The use of restration] (ii) implemented and appropriate of techniques as det in accordance with Based on document facility failed to det and/or placement of according to facility	S: RESTRAINT OR aint or seclusion must be] in accordance with safe restraint and seclusion termined by hospital policy th State law. at review and interview, the poument the appropriate type of restraint implemented ty policy and procedure for 2 of at medical records reviewed of	A 0167	1 3. Reviewed Restraint Ca Plan documentation with clin staff beginning on 2/15/2018 refresher review March 15, 2 April 6, 2018. Type of restrain documented on Restraint Flo	ical and 018 - nt

	STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         152027		r í	LDING	DNSTRUCTION 00	(X3) DATE COMPI <b>03/14</b>	LETED
NAME OF	PROVIDER OR SUPPLIE	R	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
VIBRA H	IOSPITAL OF FOR	T WAYNE			ANDALLIA DRIVE 5TH FLOOR WAYNE, IN 46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	patients in restraint	S.			Sheet.		
	Tin dia any				Prevent:		
	Findings:				Process change: Day shift nur will implement new 24 hour	se	
	1. Policy titled, "R	estraint Use"			restraint flow sheet during		
		2/18, indicated on pg. 3,			Physician and clinical rounding	a	
	~ ~	visions, bulleted point, "A			daily. New order obtained and		
		s required to initiate, change,			placed on nursing work list for	2	
		ontinue restraint. The order			hour rounding requirement.		
	must include the ty	pe and number of restraints"			Nursingshift supervisor to revi	ew	
					allrestraint patient orders for	l	
	-	nt medical records on 3/14/18			completeness to include type	and	
		317 hours indicated patient:			placement of restraint. Responsible Person:		
		Order and Flow Record,			Chief Clinical Officer		
		6/18 indicated that patient was			Monitoring:		
	in soft limb restrain				# of patients with completed		
		where the restraints were			documentation to include ty		
	placed.	Order and Elaw Decord			of restraint and placement /		
	Medical, dated:	Order and Flow Record,			of patients in restraints.		
		ated that patient was in soft					
		ut lacked documentation of					
	where the restraint	was placed.					
	b. 3/12/18 lacke	ed a checkmark in the box					
	0 51	estraint, but a number 1 was					
	· ·	nb restraint. Documentation					
		ection indicated right and left			Goal:		
	soft limb restraint.	licts the number 1 placed after			100% of patient restraint		
	soft fimb restraint.				documentation completed per		
	3 Staff & (Nurse M	Manager) was interviewed on			shift and reviewed for 3		
		nately 1339 hours, and			month.Audit data will be repor	ted	
		ve-mentioned Restraint Order			to QAPI, MEC and Governing Board.		
	and Flow Records,						
	documentation of e	either the type and/or placement					
	of restraint as requi	ired per policy and procedure.					
0168	482.13(e)(5)						
		S: RESTRAINT OR					
3ldg. 00	SECLUSION						
-	The use of restra	int or seclusion must be in					

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

AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		A. BU B. WI		00	COMPLETED 03/14/2018
	PROVIDER OR SUPPLIER			2200 R	ADDRESS, CITY, STATE, ZIP CODE RANDALLIA DRIVE 5TH FLOOR 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	other licensed ind is responsible for specified under §4 order restraint or s in accordance wit Based on document facility failed to ensi- physician or other I practitioner prior to (#3) patient medica in restraints. Findings: 1. Policy titled, "R revised/reapproved under General Prov "A physician's orde change, continue, a 2. Policy titled, "M Requirements", rev indicated on pg. 2, must be authenticat prescribing physicia 3. Review of patien at approximately 15 #3's, Restraint Orde dated: A. 3/2/18 that pati x1 from 0700 hours order is timed at 09 hours on 3/2/18 and telephone or verbal physician order for 0929 hours. B. 3/5/18 that pati x1 from 0800 hours	review and interview, the sure an order was written by a icensed independent the use of restraints for 1 of 2 l records reviewed of patients estraint Use", 2/18, indicated on pg. 3, isions section, bulleted point, r is required to initiate, nd discontinue restraint." edical Record Documentation ised/reapproved 12/16, point 7.b., "Restraint orders ed within 24 hours by the	A 0	168	<ul> <li>1. Daily Physician rounding started on 3/8/2018. Daily assessments are performed a restraints are reviewed during time. Restraint changes will be written during daily rounds.</li> <li>2. Physician orders are authenticated daily during clinical rounding.</li> <li>3. A D., 4. Restraints are discussed daily during clinical rounding. Orders completed during rounding and Restraint Flow Sheet initiated.</li> <li>Prevent Reoccurrence:         <ul> <li>Ensure physician order is authenticated every day to continue or discontinue restrait use. This is reviewed during d clinical rounding every mornin with the attending physician.</li> <li>Person Responsible:</li> <li>Chief Clinical Officer</li> <li>Monitoring:</li> <li># of completed restraint order documented on Restraint flowsheet / # of patients in restraints</li> <li>Goal:</li> <li>100% completion of physician orders daily reviewed for 3 monorders daily r</li></ul></li></ul>	this e ical int aily g ers w

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 152027 B. WING 03/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 RANDALLIA DRIVE 5TH FLOOR VIBRA HOSPITAL OF FORT WAYNE FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG hours on 3/5/18 and was not indicated to be a telephone or verbal order. The flowsheet lacked a physician order for restraint from 0800 hours to 1359 hours. C. 3/6/18 that patient was in soft limb restraint x1 from 0700 hours to 1800 hours. Physician's order is timed at 1000 hours, which is after 0700 hours on 3/6/18 and was not indicated to be a telephone or verbal order. The flowsheet lacked a physician order for restraint from 0700 hours to 0959 hours. D. 3/12/18 that patient was in soft limb restraint x1 from 0700 hours to 1300 hours. Physician's order lacked a time. The flowsheet lacked a physician order for restraint from 0700 hours to 1300 hours. 4. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation of a physician order for restraint as required per policy and procedure. A 0170 482.13(e)(7) PATIENT RIGHTS: RESTRAINT OR SECLUSION Bldg. 00 The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion. 1. Clinical team will notify Based on document review and interview, the A 0170 03/15/2018 facility failed to ensure the attending physician Admitting Physician for initial restraint order prior to application was notified of restraint use for 2 of 2 (#2 and 3) or following emergency patient medical records reviewed of patients in application of restraints. restraints. 2. A. - B., 3. Clinical team re-educated on the need to Findings: contact physician for an order when discontinuing or changing 1. Policy titled, "Restraint Use", restraints status. revised/reapproved 2/18, indicated on Attachment FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **TR3F12** Facility ID: 012132 If continuation sheet Page 8 of 24

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07/20/2018

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION 00	c - )	TE SURVEY IPLETED	
		152027	B. WING		03/*	03/14/2018	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP			
VIBRA H	IOSPITAL OF FOR	TWAYNE		RANDALLIA DRIVE 5TH T WAYNE, IN 46805	FLOOR		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
		Restraint; Initial Order section,		Prevent Reoccurrence	-		
	~	ysician/LIP (Licensed		Current physician co	-		
	-	itioner) must be contacted prior		provided by a group	of		
	~ ~	nmediately following		physicians. The atter	nding		
	emergency applica	tion of restraints".		physician will benoti	fied of an		
				initial order. Anymen	nber of the		
	2. Review of patie	ent medical records (MRs) on		attending group can	order and		
	3/14/18 at approxi	mately 1317 hours indicated		confirm the need to o	continue or		
	patient:			discontinue the need	l for		
		Order and Flow Record,		restraints. Availabilit	y of		
	Medical, dated 2/1	6/18 indicated that patient was		physician coverage i	s 24		
	in soft limb restrai	nts x2, but unable to determine		hours.			
	time applied to tim	ne discontinued because nurse		Responsible:			
	assessment every 2	2 hours was lacking. Reasons		Chief Clinical Officer			
	for restraint includ	ed, to prevent pulling at		Monitoring:			
	tubing/dressing an	d/or unable to follow safety		# of patients placed i	n		
	instructions. MR la	acked documentation the		restraints where atte			
	attending physicia	n was notified of restraint use.		notified/ # of initial re	-		
		Order and Flow Record,		order	Journa		
	Medical, dated:			Goal:			
	a. 3/5/18 indicat	ed that patient was in soft limb		100% completion of			
		800 hours to 0500 hours. MR		notification to attend	ina		
		tion the attending physician was		physician of initial or	•		
		tient was in soft limb restraint					
	•	rs to 1800 hours. MR lacked					
		attending physician was					
	notified of restrain						
		Manager) was interviewed on					
	3/14/18 at approxi	mately 1339 hours, and					
	confirmed the abo	ve-mentioned Restraint Order					
	and Flow Records	, Medical, lacked that the					
	attending physicia	n and/or LIP was notified of					
		uired per policy and procedure.					
0171	482.13(e)(8)						
<b>D</b> II		S: RESTRAINT OR					
Bldg. 00	SECLUSION	ad by State low that is more					
	restrictive	ed by State law that is more					

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		r í	ILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/14/2018
	PROVIDER OR SUPPLIEI			2200 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	(X5) COMPLETIO DATE
	<ul> <li>for the manageme self-destructive be immediate physic staff member, or or renewed in accorn limits for up to a to (A) 4 hours for ad older;</li> <li>(B) 2 hours for ch 17 years of age; of (C) 1-hour for chill Based on documen facility failed to en the duration and/or for 2 of 2 (#2 and 3) reviewed of patient</li> <li>Findings:</li> <li>Policy titled, "R revised/reapproved under General Prov Physician's Order is continue, and discon must include the ty and duration."</li> <li>Review of patie at approximately 12 A. #2, Restraint O Medical, dated 2/10 in soft limb restrain of duration and/or to B. #3, Restraint O Medical, dated 2/2 3/10-3/12/18 indica limb restraints, but duration and/or time</li> </ul>	ehavior that jeopardizes the al safety of the patient, a others may only be dance with the following otal of 24 hours: ults 18 years of age or ildren and adolescents 9 to or dren under 9 years of age; t review and interview, the sure physician orders included a time limit for use of restraint b) patient medical records is in restraints. estraint Use", 2/18, indicated on pg. 3, visions, bulleted point, "A s required to initiate, change, ontinue restraint. The order pe and number of restraints and number of restraints order and Flow Record, 6/18 indicated that patient was its, but lacked documentation time limit of restraint use. order and Flow Record, 1/18, 2/22/18, 3/1-3/6/18, and ated that patient was in soft lacked documentation of e limit of restraint use. Manager) was interviewed on	A 0		<ul> <li>1. AB., 3. Physician rounding began on 3/8/2018. Restraints are reviewed during rounding orders updated according to patient assessment.</li> <li>Prevent Reoccurrence:</li> <li>The patient is assessed by a physician daily to determine continuation of restraint use. To order to continue or discontinur restraint use is documented or restraint flow sheet. If the staff nurse sees a change in status the patient at any time, the physician will be notified and a new order will be documented and a new restraint flow sheet be started. Additionally the clirit team will determine during morning clinical rounding after assessment if the need to continue or discontinue restrait swill be updated.</li> <li>Responsible Party:</li> <li>Chief Clinical Officer Monitoring:</li> <li># of patients with daily order in place / # of patients with restraints</li> <li>ID: 012132</li> </ul>	This lee n of a will nical

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		ì í	JILDING	ONSTRUCTION <u>00</u>	(X3) DATE COMPL 03/14/	ETED	
	PROVIDER OR SUPPLIEI			2200 F	ADDRESS, CITY, STATE, ZIP CODE RANDALLIA DRIVE 5TH FLOOR		
VIBRA H	OSPITAL OF FOR	TWAYNE		FORT	WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	Ē	(X5) COMPLETION DATE
	confirmed the abov and Flow Records, documentation that	the physician order included e limit of restraint use as			Goal: 100% completion of daily restra order from physician documented, audited for3 mon and reviewed at monthly QAPI MEC and Governing Board.	ths	
A 0172 Bldg. 00	SECLUSION [Unless supersed more restrictive,] (ii) After 24 hours order for the use of the management self-destructive be other licensed ind is responsible for specified under §- authorized to orde hospital policy in a must see and ass Based on document facility failed to ent face-to-face assess licensed independe before writing a net (#2 and 3) patient r patients in restraint Findings: 1. Policy titled, "R revised/reapproved 1.b)., "A face-to-fat the attending physic	ehavior, a physician or lependent practitioner who the care of the patient as 482.12(c) of this part and er restraint or seclusion by accordance with State law less the patient. t review and interview, the sure after 24 hours that a ment by the physician or nt practitioner (LIP) was done w order for restraint for 2 of 2 medical records reviewed of s. estraint Use", 2/18, indicated on pg. 4, point ce assessment of the patient by cian is documented daily of restraint and before	Α0	172	Daily clinical rounding is conducted with physician to review and assess patient and update restraint need. A new order will be written to continue discontinue restraint use. <b>Prevent:</b> The clinical team, including the physician rounds on all patient daily to complete assessment a if there is a need to continue of discontinue use of patient restraint. New order to continue or discontinue will be complete by the physician after a face to face assessment. <b>Responsible Person:</b> <b>Chief Clinical Officer</b>	e or s and r e e	03/15/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152027	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 03/14/2018	
NAME OF PROVIDER OR SUPPLIER VIBRA HOSPITAL OF FORT WAYNE			2200 F	ADDRESS, CITY, STATE, ZIP CODE RANDALLIA DRIVE 5TH FLOOR WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E (X5) COMPLETION DATE	
	Medical, dated 2/10 in soft limb restrain after 24 hours of a	Order and Flow Record, 6/18 indicated that patient was nts, but lacked documentation face-to-face assessment by the efore writing a new order for		Monitoring: # of patients with daily order i place /# of patients with face t face assessment		
	<ul> <li>B. #3, Restraint C Medical, dated 2/2 3/10-3/12/18 indica limb restraints, but hours of a face-to-f physician or LIP be restraint.</li> <li>3. Staff 8 (Nurse N 3/14/18 at approxin confirmed the abov and Flow Records, documentation of a physician or LIP be</li> </ul>	Prder and Flow Record, 1/18, 2/22/18, 3/1-3/6/18, and ated that patient was in soft lacked documentation after 24 face assessment by the efore writing a new order for Manager) was interviewed on nately 1339 hours, and ve-mentioned Restraint Order Medical, lacked a face-to-face assessment by the efore writing a new order for d per policy and procedure.		Goal: 100% Completion of daily restraint order by physician w be reviewed for 3 month and reported to QAPI, MEC and Governing Board committees.		
A 0175 Bldg. 00	SECLUSION The condition of t restrained or secl a physician, other practitioner or train completed the train	uded must be monitored by licensed independent ined staff that have ining criteria specified in his section at an interval				
	Based on documen facility failed to en patient who is restr to intervals determ	t review and interview, the sure the condition of the ained is monitored according ined by hospital policy for 2 of t medical records reviewed of	A 0175	1., 2 AB., 3. Restraint Policy reviewed with clinical staff.Documentation/assessme nt to be providedevery 2 hour while patient is in restraints Prevent Reoccurrence: Process change will have Day Shift nurse implement restraint flow sheet during clinical	-	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	Č /	TE SURVEY IPLETED	
	152027		B. WING			03/14/2018	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO			
VIBRA H	IOSPITAL OF FOR	TWAYNE		RANDALLIA DRIVE 5TH F WAYNE, IN 46805	LOOR		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	CTION	(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE	COMPLETIO	
TAG	REGULATORY O 1. Policy titled, "H	R LSC IDENTIFYING INFORMATION)	TAG	rounding. New order ob		DATE	
	<ul> <li>2.c)., "On-going as every 2 hours or m warrants, the patie assessed and docu and Flow Record,</li> <li>2. Review of patie at approximately 1 A. #2, Restraint 0 Medical, dated 2/1 in soft limb restrait time started or end was 0800 hours. T documentation of and time every 2 h assessment was co [facility] policy." B. #3, Restraint 0 Medical, dated 3/1 in soft limb restrait time started or end time started or end time is blank. The documentation of hours that the "req</li> </ul>	ent medical records on 3/14/18 317 hours indicated patient: Drder and Flow Record, 6/18 indicated that patient was nts x2 and unable to determine ded, but physician time of order he flowsheet lacked Registered Nurse (R.N.) initials ours that the "required mpleted and care provided per Drder and Flow Record, 2/18 indicated that patient was nt x1 and unable to determine led because physician order		and placed on nursing v for 2 hour rounding requ Responsible Party: Chief Clinical Officer Monitoring: # of completed restrain sheets / # of patients in restraints Goal: 100% Completion of re flow sheet for 3 consec months. Data findings reported to QAPI, MEC Governing Board.	t flow t flow straint cutive will be		
A 0188	<ul> <li>policy."</li> <li>3. Staff 8 (Nurse I 3/14/18 at approxic confirmed the abo and Flow Records documentation of patients in restrain every 2 hours as re- procedure.</li> <li>482.13(e)(16)(v)</li> </ul>	Manager) was interviewed on mately 1339 hours, and ve-mentioned Restraint Order					
Bldg. 00	SECLUSION	O. NEOTRAINT UK					

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	

	PROVIDER OR SUPPLIER	/NE		2200 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR WAYNE, IN 46805	
(X4) ID	SUMMARY STATEM	IENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E COMPLETION
TAG		DENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	[there must be documen patient's medical record					
	The patient's response used, including the ratio use of the intervention. Based on document revier facility failed to documen use for restraints for 2 of 2 medical records reviewed	w and interview, the t rationale for continued 2 (#2 and 3) patient	A 0	188	1. A., 2. A-B, 3. Clinical team w document on Restraint Flow Sheet the reason to continue u of restraints.	00/10/201
	Findings:				Prevent: The patient is assessed by th nurse every shift to determine	
	<ol> <li>Policy titled, "Restrain revised/reapproved 2/18, A, under Medical Restrain and Documentation Requ point, "Includes assessme</li> <li>Review of patient med at approximately 1317 ho A. #2, Restraint Order an Medical, dated 2/16/18 in in soft limb restraints, but of continued reason for re p.m. shifts.</li> <li>#3, Restraint Order an Medical, dated 3/1/18 (p.n. shift) and 3/11/18 (p.m. sl patient was in soft limb re documentation of continue</li> <li>Staff 8 (Nurse Manage 3/14/18 at approximately</li> </ol>	indicated on Attachment nt; Nursing Assessment ired section, bulleted nt of continued need". ical records on 3/14/18 urs indicated patient: nd Flow Record, dicated that patient was lacked documentation straint on the a.m. and nd Flow Record, m. shift), 3/4/18 (p.m. hift) indicated that estraints, but lacked ed reason for restraint. r) was interviewed on 1339 hours, and			continuation of restraint use basedon patient safety. This sdocumented on restraint flowsheet. In addition the clinical teamincluding the physician round onthe patien daily to assess forcontinued restraint use. Responsible party: Chief Clinical Officer Monitoring: # of patients with justification for continued restraint in place / # of patients with restraints Goal: 100% assessment review of continued patient need for restraints on daily Restraint Flowsheet for 3 month. Data	1
	confirmed the above-men and Flow Records, Medic documentation of continu required per policy and pr	al, lacked ed reason for restraint as			findings will be reported to QAPI, MEC and Governing Board.	

	R MEDICARE & MEDI						OMB NO. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	JLTIPLE CO JILDING	NSTRUCTION		TE SURVEY PLETED
	or conduction	152027	B. WI		00		4/2018
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			ANDALLIA DRIVE 5TH FLOO	R	
VIBRA H	IOSPITAL OF FOR	TWAYNE			VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	BROUDENG N. IN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
A 0273 Bldg. 00	<ul> <li>(a) Program Sco</li> <li>(1) The program</li> <li>limited to, an ong</li> <li>measurable impr</li> <li>which there is ev</li> <li>health outcomes</li> <li>(2) The hospital r</li> <li>track quality indic</li> <li>of performance to</li> </ul>	TON & ANALYSIS pe must include, but not be joing program that shows ovement in indicators for idence that it will improve					
	indicator data inc and other relevant information subm the hospital's Qu Organization. (2) The hospital in to (i) Monitor the of services and c (3) The freque	must incorporate quality duding patient care data, nt data, for example, nitted to, or received from, ality Improvement must use the data collected e effectiveness and safety quality of care; and ency and detail of data					
	governing body. Based on documen facility failed to en and Performance I collected, analyzed related to restraint	e specified by the hospital's at review and interview, the asure the Quality Assessment mprovement Program (QAPI) d, and/or tracked information use to monitor the safety of services and quality of	A 0.	273	In review of the MEC minute provided to the surveyor it w discovered that the reviewed document was for an Ad Ho meeting. This special Ad Ho meeting was on 2/15/2018.	as I C	03/15/201

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	( <b>V</b> 2) M		ONSTRUCTION		MB NO. 0938-03 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	î î	JILDING	<u>00</u>	r í	PLETED
	or conduction	152027	B. W		00		4/2018
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CHT, STATE, ZIF CODE		
VIBRA H	IOSPITAL OF FOF	RT WAYNE			WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	1		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI	BE	COMPLETI
TAG	Ϋ́,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	patient care; and f	ailed to report this information			was called to review the		
	· ·	mittee to the Medical Executive			additional polices added to	the	
		) and the Governing Board			Fort Wayne library. This A		
	(GB).	,			meeting only discussed po		
					The monthly MEC regular		
	Findings:				meeting on 2/26/2018 revi		
	Ĕ				and discussed the Restrain	nt	
	1. Policy titled, "I	Restraint Use",			Review documentation.		
		d 2/18, indicated on pg. 1,			As discussed during audit,		
	under Policy section	on, bulleted point, "Data on			Restraints are discussed d	0	
	restraint use will b	be collected and reported to			MEC monthly meetings. N	ursing	
	Quality Assessme	nt/Performance Improvement			Leadership educated on		
	and on throughout	the committee reporting			3/28/2018 that auditing an		
	structure."				review processes occur du	•	
					QAPI, MEC and Governing Board.	J	
	2. Review of Ad	Hoc MEC Meeting Minutes and			board.		
		ing Minutes on 3/14/18 at					
		17 hours that were dated					
		ocumentation that the QAPI					
	-	, analyzed, tracked and/or					
	~	on related to restraint use to					
		iveness and safety of services					
	and quality of pati	ent care.					
	3. Staff 8 (Nurse)	Manager) was interviewed on					
		mately 1339 hours, and					
		PI Program was not collecting,					
		tracking all pertinent					
		d to restraint use and was not					
	reporting informat	tion to the MEC or GB as					
		ty policy and procedure. This					
	staff member is re	sponsible for The Monthly					
	Restraint Audit To	ool (MRAT) that was started in					
		and this tool was not capturing					
	all of the deficient	cies in documentation related to					
	use of restraint. In	formation not being collected,					
		and/or reported included, but					
		: type and/or placement of					
	restraint, notificati	ion of attending physician of					
	restraint use and ti	me, time of physician order,					
	time of Registered	Nurse (R.N.) signature after					

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

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 152027	A. BUILDING <u>00</u> B. WING		03/14	COMPLETED 03/14/2018	
	PROVIDER OR SUPPLII		22	REET ADDRESS, CITY, STATE, ZIP COD 200 RANDALLIA DRIVE 5TH FLC DRT WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF	TION LD BE IOPRIATE	(X5) COMPLETION DATE	
A 0450 Bldg. 00	<ul> <li>initials and time feevery 2 hours, preferestraint, patient sinitials for the a.m of plan of care, an R.N. at the bottom member indicated confusing.</li> <li>482.24(c)(1)</li> <li>MEDICAL RECO All patient medicilegible, complete authenticated in the person responses of evaluating the set with hospital poli Based on docume facility failed to effect entries including the authentication for medical records referring from the medical records referring for the medical red dated, and timed authenticated with physician."</li> <li>2. Review of patiat approximately for the medical referring for the medical</li></ul>	al record entries must be e, dated, timed, and written or electronic form by onsible for providing or ervice provided, consistent cies and procedures. Int review and interview, the nsure legible and complete but not limited to date, time, and 2 of 2 (#2 and 3) patient eviewed of patients in restraints. Medical Record Documentation vised/reapproved 12/16, , points 7.a. and b., "All entries ecord must be legible, signed, Restraint orders must be in 24 hours by the prescribing ent medical records on 3/14/18 1317 hours indicated patient: Order and Flow Record, 16/18 lacked documentation of	A 0450	Nursing to contact admitti physician for restraint ord initial Restraint low Sheet physician is not on site. Authentication will occur of physician rounding daily. Prevent: Process change: Day sh nurse will implement net hour restraint flow sheet during Physician and cli rounding daily. New ord obtained and placed on nursing work list for 2 ho rounding requirement. N shift supervisor to review restraint patient orders a patient restraint flow she completeness to include and placement of restrait Shift supervisor will revi documentation of physic	er and if during ift w 24 t nical er our lursing w all and eet for e type nt. ew cian	03/15/201	

VIBRA HOSPITAL OF FORT WAYNE       FORT WAYNE, IN 46805         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX       PREFIX       COOSS-REFERENCED DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX       COOSS-REFERENCED DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX       COOSS-REFERENCED DEFICIENCY (COOSS-REFERENCED)         restraint use with time;       c. discontinuation of restraint;       rescond.       Responsible Peic Chief Clinical Of Monitoring;         g. patient specific interventions;       n. shifts;       i.       modification of plan of care;       iii initials and signature of R.N. at the bottom of the flowsheet.       100 % of patient documentation of shift regarding r documentation of and/or was blank for:       a.         a. where the restraint Order and Flow Record, Medical, dated 2/21/18, 2/22/18, 3/1/18, 3/2/18, 3/4-3/6/18, and 3/10-3/12/18 lacked documentation of attending physician of restraint use with time;       Board.       Board.         c. time of Physician order;       d. time of Physician order;       Board.       Board.         g. precipitating/continued reason for restraint; h. patient specific interventions; i. R.N. initials for the a.m. and p.m. shifts; j. modification of plan of care; k. initials and signature of R.N. at the bottom of the flowsheet.       Image Staff (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and	COM 03/	00	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		NT OF DEFICIENCIES OF CORRECTION	
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PREFIX TAG         restraint use with time;       c. discontinuation of restraint;       record.         d. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours;       record.         e. precipitating/continued reason for restraint;       monitoring;         g. patient specific interventions;       h. R.N. initials for the a.m. and p.m. shifts;         i. modification of plan of care;       j. initials and signature of R.N. at the bottom of the flowsheet.         B. #3, Restraint Order and Flow Record, Medical, dated 2/2/1/18, 2/22/18, 3/1/18, 3/2/18, 3/4-3/6/18, and 3/10-3/12/18 lacked       Goal: 100 % of patient documentation of shift regarding r documentation of restraint use with time;         c. time of physician order;       d. time of R.N. signature after physician order;       Board.         d. time of P.N. signature after physician order;       g. precipitating/continued reason for restraint;       h. patient specific interventions;         h. patient specific interventions;       i. R.N. initials of the a.m. and p.m. shifts;       j. modification of attending physician order;         d. time of P.N. signature after physician order;       d. time of Physician order;       Board.         i. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours;       g. precipitating/continued reason for r	·	IDALLIA DRIVE 5TH FLOOR	2200 R/			
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       DEFICE TAG         restraint use with time;       c. discontinuation of restraint;       record.         d. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours;       record.         e. precipitating/continued reason for restraint;       # of completed r documentation/         j. initials for the a.m. and p.m. shifts;       i. modification of plan of care;         j. initials and signature of R.N. at the bottom of the flowsheet.       100 % of patient documentation of shift regarding r documentation of ad/or was blank for:         a. where the restraint was placed;       b. notification of plan of care;         c. time of physician order;       d. time of R.N. signature after physician order;         d. time of R.N. signature after physician order;       Board.         g. precipitating/continued reason for restraint;       f. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours;         g. precipitating/continued reason for restraint;       h. patient specific interventions;         i. R.N. initials for the a.m. and p.m. shifts;       j. modification of plan of care;         k. initials and signature of R.N. at the bottom of the flowsheet.       S. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and		TINE, IN 40005				
<ul> <li>c. discontinuation of restraint;</li> <li>d. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours;</li> <li>e. precipitating/continued reason for restraint;</li> <li>g. patient specific interventions;</li> <li>h. R.N. initials for the a.m. and p.m. shifts;</li> <li>i. modification of plan of care;</li> <li>j. initials and signature of R.N. at the bottom of the flowsheet.</li> <li>B. #3, Restraint Order and Flow Record,</li> <li>Medical, dated 2/21/18, 2/22/18, 3/1/18, 3/2/18, 3/4-3/6/18, and 3/10-3/12/18 lacked</li> <li>documentation of and/or was blank for:</li> <li>a. where the restraint was placed;</li> <li>b. notification of attending physician of restraint;</li> <li>f. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours;</li> <li>g. precipitating/continued reason for restraint;</li> <li>h. patient specific interventions;</li> <li>i. R.N. initials for the a.m. and p.m. shifts;</li> <li>j. modification of plan of care;</li> <li>k. initials and signature of R.N. at the bottom of the flowsheet.</li> </ul>	CTION SHOULD BE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	PREFIX	ICY MUST BE PRECEDED BY FULL	(EACH DEFICIEN	PREFIX
confirmed the above-mentioned Restraint Order         and Flow Records, Medical, lacked         documentation and/or had blanks as described         and facility policy and procedure was not being         followed.	ficer estraint # of patients in complete per estraint eviewed for 3 will be sent to	Responsible Person: Chief Clinical Officer Monitoring: F of completed restraint locumentation/ # of patients estraints. Goal: 00 % of patient locumentation complete per shift regarding restraint locumentation reviewed for s nonth. Findings will be sent QAPI, MEC and Governing		n of restraint; rse (R.N.) initials and time for at least every 2 hours; ontinued reason for restraint; c interventions; or the a.m. and p.m. shifts; f plan of care; nature of R.N. at the bottom of rder and Flow Record, //18, 2/22/18, 3/1/18, 3/2/18, 0-3/12/18 lacked nd/or was blank for: raint was placed; 'attending physician of me; ian order; ignature after physician order; n of restraint; rse (R.N.) initials and time for at least every 2 hours; ontinued reason for restraint; c interventions; r the a.m. and p.m. shifts; f plan of care; mature of R.N. at the bottom of Manager) was interviewed on nately 1339 hours, and e-mentioned Restraint Order Medical, lacked /or had blanks as described	<ul> <li>c. discontinuation</li> <li>d. Registered Numonitoring patient a</li> <li>e. precipitating/c</li> <li>g. patient specific</li> <li>h. R.N. initials for</li> <li>i. modification of</li> <li>j. initials and sign</li> <li>the flowsheet.</li> </ul> B. #3, Restraint O Medical, dated 2/21 3/4-3/6/18, and 3/10 documentation of a <ul> <li>a. where the restriction of</li> <li>restraint use with the</li> <li>c. time of physicid</li> <li>d. time of R.N. side</li> <li>e. discontinuation</li> <li>f. Registered Numonitoring patient a</li> <li>g. precipitating/c</li> <li>h. patient specific</li> <li>i. R.N. initials for</li> <li>j. modification of</li> <li>k. initials and sign</li> <li>the flowsheet.</li> </ul> 3. Staff 8 (Nurse M 3/14/18 at approxim confirmed the abov and Flow Records, documentation and/ and facility policy a	

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES			ОМ	B NO. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152027	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 03/14/2018	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR		
VIBRA H	IOSPITAL OF FOR	T WAYNE		WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		a follow up investigation of a pital complaint survey /18.	S 0000			
	Complaint Numbe	r: IN00254140				
	Date: 3/14/18					
	Facility Number:	012132				
	QA: 3/22/18					
0408 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSES IMPROVEMENT	SSMENT AND				
Diag. 00		2 (a)(2)(A)(B)(C)(D)				
		ed, hospital-wide,				
		uality assessment and				
	of the hospital pa	gram in which all areas				
		ongoing and have a				
		plementation that				
		not limited to, the				
	following:					
	(2) All functions, limited to the follo					
	(A) Discharge pl					
	(B) Infection con					
	(C) Medication t	nerapy. ) emergencies as				
	defined in 42					
	15-1.5-5(b)(3					
	Based on documer	nt review and interview, the	S 0408	In review of the MEC minutes		03/15/20
		nsure there was an effective,		provided to the surveyor it was	5	
		l-wide Quality Assessment and		discovered that the reviewed		
	-	ovement Program (QAPI) that		document was for an Ad Hoc		
		l, and/or tracked information		meeting. This special Ad Hoc	vio	
	related to restraint	use to monitor the		meeting was on 2/15/2018. Th	115	

Event ID: TR3F12 Facility ID: 012132 If continuation sheet Page 19 of 24

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		A. BUILDING B. WING	00	COMP1 03/14	/2018
NAME OF	PROVIDER OR SUPPLIE	D	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				RANDALLIA DRIVE 5TH FLC	OR	
VIBRA	IOSPITAL OF FOR	T WAYNE	FORT	「WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE OPRIATE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	effectiveness and s	safety of services and quality of		was called to review the		
		ailed to report this information		additional polices added to		
		mittee to the Medical Executive		Fort Wayne library. This A		
		) and the Governing Board		meeting only discussed po		
	(GB).			The monthly MEC regular		
				meeting on 2/26/2018 revi		
	Findings:			and discussed the Restrai	nt	
				Review documentation.		
	1. Policy titled, "H			As discussed during audit, Restraints are discussed of		
		d 2/18, indicated on pg. 1,		MEC monthly meetings. N	0	
	5	on, bulleted point, "Data on		Leadership educated on	ursing	
		e collected and reported to		3/28/2018 that auditing an	d	
		nt/Performance Improvement		review processes occur du		
	-	the committee reporting		QAPI, MEC and Governing		
	structure."			Prevent Reoccurrence:	5	
				Restraint flow policy revi	ewed	
		Hoc MEC Meeting Minutes and		with clinical staff on 3/15		
		ng Minutes on 3/14/18 at		Specifically reviewing		
		7 hours that were dated		expectations of restraint	flow	
		cumentation that the QAPI		sheet documentation		
	-	, analyzed, tracked and/or		completeness. Data colle	ected	
	-	on related to restraint use to		from restraint audits is		
	and quality of pati	iveness and safety of services		reported through QAPI, M	/lec	
	and quanty of part	ent care.		and Governing Board.		
	3 Staff 8 (Nurse)	Manager) was interviewed on		Responsible Party:		
		mately 1339 hours, and		Chief Clinical Officer		
	**	PI Program was not collecting,		Monitoring:		
		tracking all pertinent		# of clinical audits condu		
		d to restraint use and was not		# of clinical audits review	ved	
		ion to the MEC or GB as		through committees.		
	· -	y policy and procedure. This		Goal:		
		sponsible for The Monthly		100% review of clinical a	udits	
		ool (MRAT) that was started in		through QAPI and comm	ittees.	
		and this tool was not capturing				
		ties in documentation related to				
		formation not being collected,				
		and/or reported included, but				
		type and/or placement of				
		on of attending physician of				
	restraint use and ti	me, time of physician order,				

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

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 152027	A. BU B. WI	VILDING NG	00	COMPLETED 03/14/2018	
VIBRA H	PROVIDER OR SUPPLIE			2200 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT 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)	(X5) COMPLETIC DATE	
S 0744 Bldg. 00	<ul> <li>time of Registered 1 physician order, dis initials and time for every 2 hours, prec restraint, patient spi initials for the a.m. of plan of care, and R.N. at the bottom member indicated t confusing.</li> <li>410 IAC 15-1.5-4 MEDICAL RECOI 410 IAC 15-1.5-4</li> <li>(e) All entries in the shall be:</li> <li>(1) legible and could Based on document facility failed to ensi entries including but authentication for 2 medical records rev Findings:</li> <li>1. Policy titled, "M Requirements", rev indicated on pg. 2, into the medical record dated, and timedF authenticated within physician."</li> <li>2. Review of patient at approximately 13</li> </ul>	Nurse (R.N.) signature after continuation of restraint, R.N. monitoring patient at least ipitating/continued reason for cecific interventions, R.N. and p.m. shifts, modification /or initials and signature of of the flowsheet. This staff he MRAT was incomplete and RD SERVICES (e)(1)	S 07		1. Nursing to contact admitting physician for restraint order at initial Restraint Flow Sheet if physician is not on site. Authentication will occur durin physician rounding daily. 2. A - B., 3. Nursing education provided to clinical staff to ens completion of restraint flow sh prior to end of shift. Prevent Reoccurrence: Restraint flow policy reviewed with clinical staff on 3/15/207 Specifically reviewing expectations of restraint flow sheet documentation completeness. Data collecte from restraint audits is reported through QAPI, M	9 9 10 10 10 10 10 10 10 10 10 10	
		5/18 lacked documentation of or:			and Governing Board. Responsible Party: Chief Clinical Officer		

ENTERS FOR MEDICARE & MEDIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152027	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 03/14/2018	
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR				
VIBRA I	HOSPITAL OF FOR	TWAYNE	FORT	WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION .D BE COPRIATE	(X5) COMPLETIO DATE	
	restraint use with ti c. discontinuatio d. Registered Nu monitoring patient e. precipitating/c g. patient specifi h. R.N. initials fe i. modification o	n of restraint; urse (R.N.) initials and time for at least every 2 hours; continued reason for restraint; c interventions; or the a.m. and p.m. shifts;		Monitoring: # of clinical audits cond # of clinical audits review through committees. Goal: 100% review of clinical a through QAPI and comm	wed		
	Medical, dated 2/2 3/4-3/6/18, and 3/1 documentation of a a. where the rest b. notification of restraint use with ti c. time of physic d. time of R.N. s e. discontinuatio f. Registered Nu monitoring patient g. precipitating/c h. patient specifi i. R.N. initials for j. modification of	nd/or was blank for: raint was placed; cattending physician of me; ian order; ignature after physician order; n of restraint; rse (R.N.) initials and time for at least every 2 hours; continued reason for restraint; c interventions; or the a.m. and p.m. shifts;					
	3/14/18 at approximation of the second secon	Manager) was interviewed on nately 1339 hours, and re-mentioned Restraint Order Medical, lacked /or had blanks as described and procedure was not being					
0930	410 IAC 15-1.5-6 NURSING SERV	ICE					

 PRINTED:
 07/20/2018

 FORM APPROVED

 OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		152027	B. WING	<u></u>	03/14/2018	
NAME OF I	PROVIDER OR SUPPLI	ED	STREET	ADDRESS, CITY, STATE, ZIP CODE		
	OSPITAL OF FOI			RANDALLIA DRIVE 5TH FLOO WAYNE, IN 46805	२	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE COMPLETION DATE	
Bldg. 00	410 IAC 15-1.5-	,	IAO		DATE	
Blug. 00						
	(b) The nursing following:	service shall have the				
		nurse shall supervise e care planned for and				
	provided to each					
		ent review and interview, nursing	S 0930	1. AC. Daily clinical roundin	g is 03/15/2018	
	services failed to	supervise and evaluate the care		conducted with physician to		
	* *	o use of restraint including: type		review and assess patient ar		
	~	of restraint, modification of		update restraint need. A new order will be written to contin		
	· ·	fication of attending physician of		discontinue restraint use and		
		nitoring patient at least every 2 onale for continued use of		attending physician will be		
		2 (#2 and 3) patient medical		notified.		
		of patients in restraints.		2 3. Nursing re-educated o	n	
	records reviewed	or patients in restraints.		need for documentation		
	Findings:			completeness.		
	-			Prevent Reoccurrence:		
	1. Policy titled, "Restraint Use",			The clinical team, including the physician rounds on all patie		
		ed 2/18, indicated on:		daily to complete assessme		
		General Provisions, bulleted		and if there is a need to cont		
		, "A Physician's Order is		or discontinue use of patient		
		e, change, continue, and int. The order must include the		restraint. New order to contin	ue	
		of restraintsDocumentation is		or discontinue will be comple		
		straints are initiated, and		by the physician. In emergen	t	
	· ·	isode of restraint use and will		situations physician will be contacted after placement ar	d	
		the Nursing Care Plan: Risk for		documented on restraint flow		
	Injury".	-		sheet.		
		A, under Medical Restraint;		Responsible Person:		
		on; and Nursing Assessment and		Chief Clinical Officer		
		equired section, bulleted points,		Monitoring:		
		Licensed Independent		# of patients with complete		
		t be contacted prior to		daily order and documentat	ion	
	**	mediately following emergency traintsIncludes assessment of		in place /# of patients with		
	continued need			restraints		
		.c)., "On-going assessment				
		ally every 2 hours or more				

PRINTED: 07/20/2018 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 152027 B. WING 03/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 RANDALLIA DRIVE 5TH FLOOR **VIBRA HOSPITAL OF FORT WAYNE** FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG frequently if condition warrants, the patient's safety and other needs are assessed and documented on the Restraint Order and Flow Record, Medical ... ". Goal: 100% Completion of daily 2. Review of patient medical records on 3/14/18 restraint order by physician will be at approximately 1317 hours indicated patient: reviewed for 3 month and A. #2, Restraint Order and Flow Record, reported to QAPI, MEC and Medical, dated 2/16/18 lacked documentation of Governing Board committees. and/or was blank for: a. where the restraint was placed; b. notification of attending physician of restraint use with time; c. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours; d. continued reason for restraint; e. modification of plan of care. B. #3, Restraint Order and Flow Record, Medical, dated 2/21/18, 2/22/18, 3/1/18, 3/2/18, 3/4-3/6/18, and 3/10-3/12/18 lacked documentation of and/or was blank for: a. type (3/12/18) and/or where the restraint was placed; b. notification of attending physician of restraint use with time; c. R.N. initials and time for monitoring patient at least every 2 hours; d. continued reason for restraint; e. modification of plan of care. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records. Medical, lacked

documentation and/or had blanks as described and nursing staff were not following facility

policy and procedure.

If continuation sheet

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