	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>00</u> B. WING			ETED
		152027	B. WINC			04/25/	2018
NAME OF P	ROVIDER OR SUPPLIER	R			ANDALLIA DDIVE STILLELOOD		
VIBRA H	OSPITAL OF FORT	Γ WAYNE			ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
A 0000							
Bldg. 00							
	This visit was for the investigation of one (1) federal complaint.		A 000	00			
	•	ber: IN00258887					
		eficiency related to					
		Unrelated deficiency					
	cited.						
	D	4/04/10 14/05/10					
	Date of survey:	4/24/18 and 4/25/18					
	Facility number:	012122					
	racinty number.	012132					
	QA: 5/3/18						
	Q11. 0/3/10						
	400 004 \(\(\)						
A 0395	482.23(b)(3)	N OF NURSING CARE					
Bldg. 00		e must supervise and					
Diag. 00	•	ng care for each patient.					
	Based on docum	ent review and interview	A 039)5	S-395		05/18/2018
	the facility failed	d to ensure a Registered			1. CCO and Educator will cond		
	Nurse followed	physician orders and			inservices and re-education or the Vital Signs Policy and	1	
	facility policy re	lated to assessments for 2			Procedure with all CNA's, Nurs	ses	
	of 10 patients				and Supervisors.		
	(patients #6 and	10).			2. Education will be completed	l by	
					May 18, 2018. 3. Supervisor will conduct a		
	Findings include	;;			monthly random audit of 20		
					charts per week for 4 months t	to	
	1. Facility polic	y titled "Guidelines for			ensure 100% compliance.		
		ast reviewed/revised			CCO is ultimately responsib for above plan of correction.	oie	
	January 2018 inc	dicated the following: "			Expected date of completion		
					•		

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

TITLE

012132

(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.

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	JLTIPLE CO ILDING	00	(X3) DATE COMPL	
THINDTEIN	or condition	152027	B. WI		00	04/25/	
		102021		CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	0 1/20/	2010
NAME OF I	PROVIDER OR SUPPLIER				ANDALLIA DRIVE 5TH FLOOR		
VIBRA H	OSPITAL OF FORT	WAYNE			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	is:		DATE
		: A specific physician			05/18/18		
	order will supersede the minimum frequencies notedRoutines/Guidelines						
	_	OU [High Ops Unit]					
	1	PR [temperature, pulse,					
		[blood pressure], SAO2					
		on])Every 4 hours and					
	with change in c						
	with change in c	onution					
	2 Review of na	tient #6's medical record					
	2. Review of patient #6's medical record indicated the following:						
	(A) The patient had a physician order for						
		urs with start date of					
		m. and no stop date.					
		of acute and chronic					
	respiratory failur						
	(B) The medical						
	` ′	or vital signs every 4					
		lowing dates and times:					
		00 a.m., 4:00 a.m. and					
	6:52 p.m.	,					
	4/10/18 at 1:	15 a.m. and 5:15 a.m.					
	4/11/18 at 2:	34 a.m.					
	4/12/18 at 3:	30 a.m. and 9:44 p.m.					
	4/13/18 at 3:	11 a.m., 7:11 a.m. and					
	8:26 p.m.						
	4/14/18 at 2:	26 a.m., 12:23 p.m., 4:23					
	p.m. and 8:57 p.1	m.,					
	(C) The medical	l record lacked					
	documentation o	f blood pressure and					
	oxygen saturatio	n assessed or					
	documented						
	on 4/9/18 at 2:52	2 p.m.					
	(D) The medica	l record lacked					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE COMPI 04/25	LETED	
	ROVIDER OR SUPPLIER		2200	ET ADDRESS, CITY, STATE, ZIP CODI RANDALLIA DRIVE 5TH FLO T WAYNE, 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	documented on 4 4/9/18 at 9:15 p.: and 5:44 p.m., 4/4/15/18 at 7:45 at 4/19/18 at 6:43 p. a.m., 4/23/18 at at 3:20 a.m. (E) The medical documentation of pressure assessed 4/10/18 at 10:58 4/11/18 at 5:33 at and 11:31 p.m. 4/11/18 at 5:33 at and 11:31 p.m. 4/17/18 at 3/19:48 a.m. and 11 (F) The medical documentation of pressure and oxyor documented of and 4/21/18 at 8/19 (G) The medical documentation of a 4/20/18 at 12:00 (H) The medical documented on 4/20/18 at 12:00 (H) The medical documentation of a 4/20/18 at 3:50 p. 3. Review of pa	f temperature and blood d or documented on a.m. and 10:34 p.m., a.m., 4/12/18 at 4:59 a.m. d/13/18 at 8:06 a.m. and d/18 at 5:34 a.m., 8:23 at 25 p.m., 4/20/18 at 14 p.m. record lacked f diastolic blood gen saturation assessed in 4/11/18 at 12:27 p.m. in the temperature and in assessed or asse				
	record indicated	the following:				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î í		NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		152027	B. W	ING		04/25/	2018
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					ANDALLIA DRIVE 5TH FLOOR		
VIBRA H	OSPITAL OF FORT	WAYNE		FORTW	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	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		had a physician order for					
	vital signs every 4 hours with a start date						
		0 a.m. and no stop date.					
	_	of acute on chronic					
	respiratory failui						
	(B) The medica						
		or vital signs every 4					
		lowing dates and times:					
		0 a.m. and 8:30 p.m.					
		30 a.m. and 4:30 a.m.					
	4/7/18 at 5:14 p.m.						
	4/8/18 at 3:3	0 a.m., 6:19 p.m. and					
	10:19 p.m.						
	4/9/18 at 2:1	9 a.m. and 3:30 p.m.					
	4/10/18 at 4:	15 a.m. and 12:12 p.m.					
	(C) The medica	l record lacked					
	documentation of	f temperature assessed or					
	documented on 4	4/6/18 at 11:30 p.m.					
	(D) The medica	l record lacked					
	documentation of	f blood pressure and					
	temperature asse	essed or documented on					
	_	o.m., 4/8/18 at 10:41 a.m.					
	and 4/9/18 at 11:						
	4. During an int	erview with A1 (Director					
	of Quality Mana	gement) on 4/25/18 at					
		e verified lack of					
	-	of complete vitals every 4					
		by the physician for					
	patient #6.	J - F J					
	5. During an int	erview with A3 (Chief					
		on 4/25/18 at 7:50 p.m.,					
		ack of documentation of					
	l, siie veriiied it	The of documentation of					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		A. BUILDING B. WING	00	COMPLETED 04/25/2018	
	PROVIDER OR SUPPLIER	2200 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR WAYNE, IN 46805		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	by the physician for patient #10.				
A 0397	482.23(b)(5) PATIENT CARE ASSIGNMENTS				
Bldg. 00	A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. Based on document review and	A 0397	S-397	05/25/2018	
	interview, the facility failed to ensure nursing staff were educated and competent in the care of a patient with an arterial line prior to the patient's admission to the facility for 10 of 10 Registered Nurses whom cared for patient #2. (#N1, N2, N3, N4, N5, N6, N7, N8, N9 and N10)		Arterial line policy will be reviewed and approved through the hospital committee approvements. This will be completed the next scheduled MEC meet on 5/21/18. All HOU staff will have a competency completed and will be checked off on arterial lines. Educator and CCO will overse this process.	gh val val at ting a iill s.	
	Findings include; 1. Facility policy titled "Clinical Staff Competency" last reviewed/revised 11/2016 indicated the following: "POLICY: Vibra Hospital of Fort Wayne has established and implements a mechanism for evaluating the competency of clinical staff to ensure that each employee is capable of performing the duties to which he/she is assigned per organizational, state, and federal requirements. Clinical staff competencies are designed to establish and maintain a patient care environment				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		152027	B. W	ING		04/25/	2018
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
VIDDALI	00DITAL OF FORT	- \^/ \ \ \ \ \ \ =			ANDALLIA DRIVE 5TH FLOOR		
	OSPITAL OF FORT	WAYNE		FORTV	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BEIGEROT		DATE
		e well-being of patients,					
	visitors, and staff. Competency measurements consist of current						
	-	ence in specialty area,					
		essential skills, and					
		viors are the linking of					
	_	kills adjusted to patient					
		ons: A. Competence is					
	l	elements: a specific					
	knowledge base,	ŭ					
	equipment and performing procedures,						
		at integrate critical					
	_	ndards to meet the					
	_	nd achieve desired					
	outcome						
	PROCEDURE:						
	_	stablish competency					
		on the characteristics of					
	_	services provided, risk					
		uency of occurrence and					
		2. All competency skills					
		be approved through the					
		tment prior to use3.					
	Leaders are response						
	_	ll staff is assessed,					
	_	roved, and demonstrated					
		of employment. 4.					
		l be measured against					
	established stand	_					
	designated interv	· ·					
	1	onsist of self-study					
		of policy/procedures,					
	_	ence with preceptor or					
	qualified observe	er. 6. Competence may					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL	
		152027	B. WI		00	04/25/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ANDALLIA DRIVE 5TH FLOOR		
VIBRA H	OSPITAL OF FORT	WAYNE		FORT V	VAYNE, IN 46805		
(X4) ID	SUMMARY S	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	DEFICIENCY)		DATE
	the following: a	at is not limited to any of					
	_	ills observed, verified,					
	_	a qualified observer,					
	_	acator. b. Observation of					
		ent performance. c.					
		Testing9. Staff					
		based on their education,					
	_	isure and assessment of					
	_	nce. 10. Staff for whom					
	certain competencies have not been						
	established may be assigned patient care						
	responsibilities i	• •					
	-	rvision is available"					
	2. Job description	on titled "Chief Clinical					
		[Long Term Acute					
		wed/revised 5/2017					
	indicated the fol	lowing: POSITION					
	SUMMARY: R	esponsible for directing					
	and facilitating t	he activities of nursing					
	and clinical serv	ices. Assumes an active					
	leadership role ii	n the hospital's decision					
	making structure	and process. Ensuring					
	and facilitates co	ompetence of the clinical					
	staff, appropriate	e staffing for patient care,					
	and clinical prog	ram development.					
		priate staff for the acuity					
	_	Works closely with					
	_	dress patient care needs					
		ent care systems.					
		eility through active					
		participation in external					
	and internal activ	vities concerning health					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED	
		152027	B. W	ING		04/25/2018	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
\/IDDA.II	OODITAL OF FORT	- \A/A\/A =			ANDALLIA DRIVE 5TH FLOOR		
	OSPITAL OF FORT	VVATNE		FORT	VAYNE, IN 46805	<u> </u>	
(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 LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE	1
TAG	care services. Po	,		TAG		DATE	-
	SUPERVISORY RESPONSIBILITIES: Supervises the following positions:						
	-	rects designated clinical					
		ich may include, but are					
		arsingand staff					
	· · · · · · · · · · · · · · · · · · ·	•					
	development'						
	3 Job description	on titled "Nurse					
	3. Job description titled "Nurse Supervisor - LTAC" last						
	_	d 2/2015 indicated the					
		ITION SUMMARY:					
	Responsible fo						
	^	d coordination of nursing					
		s for the scheduled					
		accordance with					
		sophy, objectives and					
	_	ospital. The supervisor					
	works with empl	-					
	•	elop systems and					
	_	ssary for daily operations,					
	_	ining, information and					
	support to solve	-					
		signed objectives.					
	POSITION SUP	5					
		TIES: Supervises:					
		ing Support Staff.					
		ON:Facilitates staff					
		all levels of nursing					
	_	njunction with the Nurse					
	Educator"	njunion mun mo mano					
	4. Job description	on titled "Registered					
	_	last reviewed/revised					
	l			l			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/25/2018	
	PROVIDER OR SUPPLIER		2200 R	ADDRESS, CITY, STATE, ZIP CODE RANDALLIA DRIVE 5TH FLOOF WAYNE, 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)	(X5) COMPLETION DATE
	components of the include demonst competence; many improving quality professional skill responsibilities of and developing of specialty" 5. Review of particle of particle of the patient was 2055 hours and 6 wean on 3/29/18 "Nursing ICU Admission Assest 03/27/2018 TimeComment: AR GROIN, LINE Z WAVE FORM, NS [Normal Salis "Patient Care [hours]Right leveled and zero 6. Review of #N N7, N8, N9 and Nurses) personne transcripts begin p.m. with A4 (H	MMARY:Specific ne Registered Nurse role rating clinical maging patient care; y of care;utilizing ls; fulfilling of the role of the hospital; clinical expertise per tient #2's medical record to p.m., indicated the admitted on 3/27/18 at expired via terminal 1524. [Intensive Care Unit] ssmentDate: e: 20:56 [hours] T LINE IN RIGHT EERO AND GOOD PRESSURE BAG ON ne] 500 ML BAG" Notes3/29/18 11:10 Artial [Arterial] line is"			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		(X2) MULTIPLE CO A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 04/25/2018	
	PROVIDER OR SUPPLIER		2200 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR VAYNE, 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
		tation of any completed lated to arterial line			
	Clinical Officer) a.m., he/she indi patients with PIC central catheter) peripheral lines. does not admit p and has not adm	erview with A3 (Chief on 4/24/18 at 11:15 cated the facility admits CC (peripherally inserted lines, central lines, and A1 indicated the facility patients with arterial lines itted patients with ing the time period of 18.			
	Supervisor) on 4 he/she indicated patients with arte has had one arte and it was appro	erview with N2 (Unit /24/18 at 1:45 p.m., the unit currently had no erial lines. N2 indicated rial line in the last year ximately 2 months ago. patient with the arterial d with it.			
	4/24/18 at 3:00 p facility typically with an arterial l always ask that i addressed prior t A8 indicated he/ couple of weeks expired that ther	erview with A8 on o.m., she indicated the does not accept patients ine. Facility normally t is discontinued or to arrival to the facility. She had just found out a ago after the patient had e was a patient admitted ine. A8 verified it was a			

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UUT611

Facility ID: 012132

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PRINTED: 05/24/2018 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULT A. BUILD		NSTRUCTION 00	(X3) DATE : COMPL	
1111212111	or condition,	152027	B. WING		00	04/25/	
	PROVIDER OR SUPPLIER	<u> </u>	2	200 RA	DDRESS, CITY, STATE, ZIP CODE NDALLIA DRIVE 5TH FLOOR /AYNE, IN 46805		
					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	problem and he/	she had not verified the					
	•	npetency related to the					
	arterial line.						
	10. During an ir	nterview with A3 on					
	4/24/18 at 3:05 p.m., he/she indicated the						
	facility has the c						
	equipment to car	re for a patient with an					
	arterial line. A3	verified he/she was					
	unaware there was a patient admitted						
	with an arterial line until A8 had						
	mentioned in their interview on 4/24/18						
	at 3:00 p.m. A3 verified the facility does						
	not accept patier	nts with an arterial line.					
	11. During an ir	nterview with A5 (Chief					
	Marketing Offic	er) on 4/24/18 at 3:10					
	p.m., he/she indi	cated they were unaware					
	of any patients a	dmitted with an arterial					
	line.						
		nterview with A8 on					
	_	o.m., he/she indicated					
		ing and competency was					
	not part of the ar	•					
	department spec						
	0 1	encies even on the HOU					
		. He/she indicated on the					
	_	t specific competencies					
		on on arterial lines, but					
		arked it N/A (not					
		use the facility did not					
	* *	vith arterial lines and so					
	it did not apply.	A8 indicated he/she was					

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Event ID:

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Facility ID: 012132

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED	
		152027	B. W.	ING		04/25/	2018
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VIBRA H	OSPITAL OF FORT	WAYNE			ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	tient who was admitted					
		ine a couple of weeks					
	ago in an informal meeting. A8 was						
	unable to state the date, who was in the						
	meeting or what	meeting or what the meeting was about.					
	13. During an in	3. During an interview with A7					
	(Clinical Liaison	Registered Nurse) on					
	4/25/18 at 12:40	4/25/18 at 12:40 p.m., he/she indicated					
	they unaware par	tient #2 had a femoral					
	arterial line. He/she indicated they do not						
	obtain admission	·					
		oes notify the physician.					
	A7 verified Facil						
		ients with arterial lines,					
		not trained on them and					
	arterial lines are						
		17 indicated he/she was a					
		cility #2 prior to taking					
	the position of C	linical Liaison.					
	14 5	4					
		iterview with A8 on					
		o.m., he/she verified					
		not provided arterial line					
	_	on because the facility					
	does not admit p	atients with arterial lines.					
	_	iterview with A3 on					
		o.m., he/she verified					
	1 *	ical record that the					
	_	terial line while inpatient					
	at the facility.						

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

Event ID:

UUT611

Facility ID: 012132

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		152027	B. W	ING		04/25/	2018
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
A 0467	482.24(c)(4)(vi)						
	CONTENT OF RE						
Bldg. 00	ORDERS,NOTES						
	[All records must document the following, as						
	appropriate:]	rders, nursing notes,					
	•	nt, medication records,					
	•	oratory reports, and vital					
		formation necessary to					
	monitor the patien	t's condition.					
	Based on docum	ent review and	A 0	467	S-467		05/01/2018
	interview, the facility failed to ensure a				Nursing supervisor will be		
	complete and acc	curate medical records			responsible for ensuring that 100% of all admissions have a		
	which included ensuring the patients had				physician order to admit to	1	
		r to admit inpatient for 4			inpatient status and that they a	are	
		2, 6, 7, 9) a discharge			completed when hospitalists a		
	*	patients (Patient #10) or			not on the unit.		
		r for a femoral arterial		2. Supervisor will audit and			
					validate all admission orders a provide the CCO with the audi		
	-	eatients who were			results.	·	
	admitted inpatier	it. (Patient #2)			3. Admission checklist will be		
					completed by supervisor on 10	00%	
	Findings include	•			of all admissions.		
					4. Audits on items 2 & 3 above		
	1. Facility policy	y titled "Medical Record			will be completed by superviso		
	Documentation I	Requirements LTCH			and turned in to CCO on a webbasis.	ек іу	
	[Long Term Care	e Hospital] and IRF			5. Audits will be conducted on	all	
		ilitation Facility]" last			admissions to ensure 100%	a	
		April 2018 indicated			compliance; Data will be		
		OLICY: All medical			conducted of all admissions fo	ır	
	•				the next 4 months.		
		ain documentation to			6. CCO is ultimately responsib	ile	
		and treatment provided.			for above plan of correction.		
	PROCEDURE:	•			Expected date of completion is:		
		contains the statement:			05/01/18		
	a. LTAC - Admit as an inpatient to (name						
	of facility)16.	Discharge order"					
						ļ	

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Event ID:

UUT611 Facility ID: 012132

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
THIS TETHY	or conduction	152027	B. WI		00	04/25/	
		102027		CTDEET A	DDDEGG CITY CTATE ZID CODE	0 1/20/	2010
NAME OF F	PROVIDER OR SUPPLIER				.DDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR	1	
VIBRA H	OSPITAL OF FORT	WAYNE			VAYNE, IN 46805	1	
(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	DLI ICILIACI)		DATE
	_	tient #2's medical record					
	indicated the following	_					
	at 2055 hours.	was admitted on 3/27/18					
		ICI I I Internaire Com					
	I ' '	ICU [Intensive Care					
	03/27/2018 Time	AssessmentDate:					
		T LINE IN RIGHT					
	GROIN, LINE ZERO AND GOOD						
	WAVE FORM, PRESSURE BAG ON						
	NS [Normal Saline] 500 ML BAG"						
	"Patient Care Notes3/29/18 11:10						
		Artial [Arterial] line is					
	leveled and zero						
	(C) The medica						
	1 * *	to admit inpatient and a					
		related to the patient's					
	right femoral art	eriai line.					
	3. Review of pa	tient #6's medical record					
	indicated the fol	lowing:					
	(A) The patient v	was admitted on 4/8/18 at					
	1706 hours.						
	(B) The medica	l record lacked a					
	physician order t	to admit inpatient or					
	admit to ICU wh	en the patient was					
	transferred from	medical/surgical area to					
	the HOU [High (Ops Unit] on 4/17/18.					
	4. Review of pa	tient #8's medical record					
	indicated the foll	lowing:					
	(A) The patient v	was admitted on 4/11/18					
	at 1418 hours.						
	(B) The medica	l record lacked a					

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Event ID:

UUT611

Facility ID: 012132

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED
		152027	B. W	ING		04/25/2018
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLI EIER			2200 RA	ANDALLIA DRIVE 5TH FLOOR	
VIBRA H	OSPITAL OF FORT	T WAYNE		FORT V	VAYNE, IN 46805	
(X4) ID	SUMMARY S	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 APPROPRIAT	
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	physician order t	to admit inpatient.				
	-	tient #9's medical record				
	indicated the foll	•				
		was admitted on 4/12/18				
	at 2035 hours.					
	(B) The medical					
	physician order t	to admit inpatient.				
	6. Review of patient #10's medical record indicated the following:					
	(A) The patient was admitted on 4/4/18 at					
	2116 hours and o	discharged to home on				
	4/10/18 at 1659	hours.				
	(B) The medical	l record lacked a				
	physician order t	to discharge the patient to				
	home.					
	7. During an int	erview with A3 on				
	4/25/18 at 5:56 p	o.m., he/she indicated				
	patient #6 had no	o order to admit to				
	inpatient at the fa	acility or an admit to				
	inpatient once th	e patient was transferred				
	from the medica	l/surgical area to the				
		3. He/she indicated the				
		ferred due to being				
	1 ^	lizem drip and should've				
	had a physician of	_				
	1 2	ve care (HOU) unit.				
		,				
	8. During the m	edical records review				
	_	24/18 at 4:00 p.m. with				
		eal Officer), he/she				
	`	rmation in the patients				

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Event ID:

UUT611 Facility ID: 012132

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	INSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	152027	B. W		00	04/25/	
		102021	<i>D.</i> W		DDDDGG CVTV CT TT TT TT TT	04/23/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE 5TH FLOOR		
VIBRA H	OSPITAL OF FORT	WAYNE			VAYNE, IN 46805		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		D's medical records.		TAG			DATE
	#2, 0, 8, 9 and 10) s iliculcal fectius.					
	9. During an into	erview with A3 on					
	_	o.m., he/she verified					
	-	ical record that the					
	-	terial line while inpatient					
	at the facility.						
	•						
S 0000							
5 0000							
Bldg. 00							
	This visit was for the investigation of one		S 0	000			
	(1) state complai	nt.					
	Complaint Numb	per: IN00258887					
		eficiency related to					
	_	Unrelated deficiency					
	cited.						
	Date of survey:	4/24/18 and 4/25/18					
	Ţ						
	Facility number:	012132					
	0.1.5/0/10						
	QA: 5/3/18						
S 0732	410 IAC 15-1.5-4						
	MEDICAL RECOF						
Bldg. 00	410 IAC 15-1.5-4(d)(1)(2)(3)(4)					
	(d) The medical re	cord shall contain					
	sufficient informati						
	(1) identify the se	tiont:					
	(1) identify the part(2) support the dia						
	(3) justify the trea						

State Form Event ID: UUT611 Facility ID: 012132 If continuation sheet Page 16 of 31

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		152027	B. W	ING		04/25/	/2018
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			ANDALLIA DRIVE 5TH FLOOR		
VIBRA H	OSPITAL OF FOR	ΓWAYNE			WAYNE, IN 46805		
(X4) ID	SUMMARY S	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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(4) document acc	curately the course					
	Based on docum		$\int S 0$	722	S-732		05/01/2018
			30	132	1. Nursing supervisor will be		03/01/2018
		cility failed to ensure a			responsible for ensuring that		
	-	curate medical records			100% of all admissions have a	a	
		ensuring the patients had			physician order to admit to		
		er to admit inpatient for 4			inpatient status and that they a		
	of 10 (Patients #	2, 6, 7, 9 a discharge			completed when hospitalists a not on the unit.	ıre	
	order for 1 of 10	patients (Patient #10) or			2. Supervisor will audit and		
	a physician orde	r for a femoral arterial			validate all admission orders a	and	
	line for 1 of 10 p	patients who were			provide the CCO with the audi	it	
	admitted inpatient. (Patient #2)				results.		
		,			Admission checklist will be	,	
	Findings include	<u>.</u>			completed by supervisor on 10	00%	
	1 mamgs merade	·,			of all admissions. 4. Audits on items 2 & 3 above	,	
	1 P 117 17 .	C41 . 1 UN 4 . 12 1 D 1			will be completed by supervisor		
		y titled "Medical Record			and turned in to CCO on a we		
		Requirements LTCH			basis.	•	
	_ ~	re Hospital] and IRF			5. Audits will be conducted on	all	
	[Inpatient Rehab	oilitation Facility]" last			admissions to ensure 100%		
	reviewed/revised	d April 2018 indicated			compliance; Data will be		
	the following: F	POLICY: All medical			conducted of all admissions for the next 4 months.)r	
	records will con	tain documentation to			6. CCO is ultimately responsib	ole	
	substantiate care	e and treatment provided.			for above plan of correction.		
		7. The inpatient			·		
		contains the statement:					
		it as an inpatient to (name					
		-					
	oi iacility)16.	Discharge order"					
	2. Review of pa	tient #2's medical record					
	indicated the fol						
		was admitted on 3/27/18					
	at 2055 hours.	was admitted on 5/2//10					
		ICII [Intonoivo Com					
	. ,	ICU [Intensive Care					
	Unit] Admission	AssessmentDate:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/25/2018	
	F PROVIDER OR SUPPLIEF		2200 F	ADDRESS, CITY, STATE, ZIP CODE RANDALLIA DRIVE 5TH FLOOF 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	GROIN, LINE 2 WAVE FORM, NS [Normal Sal "Patient Care [hours]Right leveled and zero (C) The medica physician order physician order right femoral art 3. Review of pa indicated the fol (A) The patient 1706 hours. (B) The medica physician order admit to ICU wh transferred from the HOU [High 4. Review of pa indicated the fol (A) The patient at 1418 hours. (B) The medica physician order 5. Review of pa indicated the fol 5. Review of pa indicated the fol	T LINE IN RIGHT ZERO AND GOOD PRESSURE BAG ON ine] 500 ML BAG" Notes3/29/18 11:10 Artial [Arterial] line is" I record lacked a to admit inpatient and a related to the patient's rerial line. Itient #6's medical record lowing: was admitted on 4/8/18 at I record lacked a to admit inpatient or nen the patient was medical/surgical area to Ops Unit] on 4/17/18. Itient #8's medical record lowing: was admitted on 4/11/18 I record lacked a to admit inpatient. Itient #9's medical record			

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PRINTED: 05/24/2018 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		A. BUILDING 00 B. WING			COMPLETED 04/25/2018		
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
VIBRA H	OSPITAL OF FORT	WAYNE			ANDALLIA DRIVE 5TH FLOOR VAYNE, 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	(B) The medical physician order to	I record lacked a to admit inpatient.					
	record indicated (A) The patient v 2116 hours and c 4/10/18 at 1659 v (B) The medica	was admitted on 4/4/18 at discharged to home on hours.					
	4/25/18 at 5:56 p patient #6 had no inpatient at the fa inpatient once th from the medica HOU on 4/17/18 patient was trans placed on a Card had a physician of	erview with A3 on o.m., he/she indicated o order to admit to acility or an admit to be patient was transferred al/surgical area to the sterred due to being dizem drip and should've order to admit to we care (HOU) unit.					
	beginning on 4/2 A3 (Chief Clinic verified the informula was serified was serif	edical records review 24/18 at 4:00 p.m. with eal Officer), he/she rmation in the patients 0's medical records. erview with A3 on o.m., he/she verified ical record that the terial line while inpatient					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		A. BUILDING B. WING	00	COMPLETED 04/25/2018
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) at the facility.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview the facility failed to ensure a Registered Nurse followed physician orders and facility policy related to assessments for 2 of 10 patients (patients #6 and 10). Findings include; 1. Facility policy titled "Guidelines for Nursing Care" last reviewed/revised January 2018 indicated the following: "PROCEDURE: A specific physician order will supersede the minimum frequencies notedRoutines/GuidelinesVital Signs - HOU [High Ops Unit]Vital signs (TPR [temperature, pulse, respirations], BP [blood pressure], SAO2 [oxygen saturation])Every 4 hours and with change in condition" 2. Review of patient #6's medical record indicated the following:	S 0930	S-930 1. CCO and Educator will con inservices and re-education of the Vital Signs Policy and Procedure with all CNA's, Nur and Supervisors. 2. Education will be completed May 18, 2018. 3. Supervisor will conduct a monthly random audit of 20 charts per week for 4 months ensure 100% compliance. 4. CCO is ultimately responsite for above plan of correction.	nses d by

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		A. BUILDING B. WING	<u>00</u>	COMPLETED 04/25/2018	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
VIBRA H	OSPITAL OF FORT	WAYNE		RANDALLIA DRIVE 5TH FLOOR WAYNE, 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)	(X5) COMPLETION DATE
	vitals every 4 ho 4/8/18 at 8:00 p.1 Admit diagnosis respiratory failur (B) The medical documentation for the foll 4/9/18 at 12:0 6:52 p.m. 4/10/18 at 1: 4/11/18 at 2:: 4/12/18 at 3:: 4/13/18 at 3: 8:26 p.m. 4/14/18 at 2:: p.m. and 8:57 p.1 (C) The medical documentation of oxygen saturation documented on 4/9/18 at 9:15 p.1 and 5:44 p.m., 4/4/15/18 at 7:45 at 4/19/18 at 6:43 p. a.m., 4/23/18 at at 3:20 a.m. (E) The medical documentation of pressure assessed	record lacked or vital signs every 4 owing dates and times: 00 a.m., 4:00 a.m. and 15 a.m. and 5:15 a.m. 34 a.m. 30 a.m. and 9:44 p.m. 11 a.m., 7:11 a.m. and 26 a.m., 12:23 p.m., 4:23 m., record lacked f blood pressure and n assessed or 4/9/18 at 2:52 p.m. 1 record lacked f temperature assessed or 4/9/18 at 8:08 p.m., m.,4/12/18 at 2:15 p.m., 13/18 at 4:26 p.m., .m. and 11:51 p.m., .m., 4/21/18 at 7:35 11:36 p.m. and 4/24/18			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JLTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
111121211	or country.	152027	B. WI		00	04/25/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE	0 20.	
NAME OF I	PROVIDER OR SUPPLIER	8			ANDALLIA DRIVE 5TH FLOOR		
VIBRA H	OSPITAL OF FORT	ΓWAYNE			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	DEFICIENCT)		DATE
		a.m., 4/12/18 at 4:59 a.m.					
	and 11:31 p.m. 4/13/18 at 8:06 a.m. and 10:56 p.m., 4/14/18 at 5:34 a.m., 8:23						
		8:25 p.m., 4/20/18 at					
	9:48 a.m. and 11						
	(F) The medical	•					
	` '						
	documentation of diastolic blood						
	pressure and oxygen saturation assessed						
	or documented on 4/11/18 at 12:27 p.m. and 4/21/18 at 8:19 a.m.						
	(G) The medical record lacked						
	documentation of the temperature and						
	oxygen saturation assessed or						
		4/13/18 at 11:50 a.m. and					
	4/20/18 at 12:00						
	(H) The medical	-					
	` ′	of temperature and					
		ssed or documented on					
	4/20/18 at 3:50 g						
	1/20/10 at 3.50 p	,					
	-	tient #10's medical					
	record indicated	· ·					
		had a physician order for					
	vital signs every	4 hours with a start date					
	of						
		a.m. and no stop date.					
		of acute on chronic					
	respiratory failur						
	(B) The medica						
		or vital signs every 4					
		lowing dates and times:					
		0 a.m. and 8:30 p.m.					
		30 a.m. and 4:30 a.m.					
	4/7/18 at 5:1	4 p.m.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. JILDING	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	152027	B. W		00	04/25/	
		152027	В. W			04/23/	2016
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VIBRA H	OSPITAL OF FORT	WAYNE			ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	EFICIENCY)	
	4/8/18 at 3:3	0 a.m., 6:19 p.m. and					
	10:19 p.m.						
	4/9/18 at 2:1	9 a.m. and 3:30 p.m.					
	4/10/18 at 4:	15 a.m. and 12:12 p.m.					
	(C) The medical	l record lacked					
	documentation o	f temperature assessed or					
	documented on 4/6/18 at 11:30 p.m.						
	(D) The medica	l record lacked					
	documentation o	f blood pressure and					
	temperature assessed or documented on 4/7/18 at 11:32 p.m., 4/8/18 at 10:41 a.m.						
	and 4/9/18 at 11:37 a.m.						
	4. During an int	erview with A1 (Director					
	_	gement) on 4/25/18 at					
	6:15 p.m., he/she	•					
		f complete vitals every 4					
		by the physician for					
	patient #6.	3 1 3					
	1						
	5. During an int	erview with A3 (Chief					
		on 4/25/18 at 7:50 p.m.,					
		ack of documentation of					
		every 4 hours as ordered					
	by the physician						
	J 1 J 2 2 3.2.2						
S 0936	410 IAC 15-1.5-6 NURSING SERVI	^E					
Bldg. 00	410 IAC 15-1.5-6						
g. 00							
		ervice shall have the					
	following:						
	(6) All nursing per	sonnel shall					
		document competency in					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		152027	B. Wl	ING	04/25/2018		
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			2200 R	ANDALLIA DRIVE 5TH FLOOR		
	OSPITAL OF FORT	ΓWAYNE		FORT V	WAYNE, 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	DEFICIENCY)		DATE
	fulfilling assigned Based on docum	-	S 09	026	S-936		05/25/2018
			303	930	1. Arterial line policy will be		03/23/2018
		cility failed to ensure			reviewed and approved through	jh	
	nursing staff we				the hospital committee approv		
		e care of a patient with an			process. This will be complete		
	arterial line prior	•			the next scheduled MEC meet	ing	ng
		facility for 10 of 10			on 5/21/18. 2. All HOU staff will have a	1	
	Registered Nurse	es whom cared for			competency completed and wi		
	patient #2. (#N1	1, N2, N3, N4, N5, N6,			be checked off on arterial lines		
	N7, N8, N9 and	N10)			Educator and CCO will overse	е	
					this process.		
	Findings include	2.			3. 100% compliance will be achieved on all HOU staff.		
					4. CCO is ultimately responsib	ماد	
	1. Facility polic	y titled "Clinical Staff			for above plan of correction.		
		st reviewed/revised			·		
	11/2016 indicate						
		bra Hospital of Fort					
		olished and implements a					
	mechanism for e	_					
		•					
		linical staff to ensure that					
		s capable of performing					
		ich he/she is assigned per					
	organizational, s	-					
	requirements. C						
	_	e designed to establish					
	and maintain a p	atient care environment					
	that promotes the	e well-being of patients,					
	visitors, and staf	f. Competency					
	measurements co	onsist of current					
	licensure, experi	ence in specialty area,					
	_	, essential skills, and					
	_	viors are the linking of					
		skills adjusted to patient					
	_	ons: A. Competence is					
	l needs. Deminin	ons. 11. Competence is					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	00	(X3) DATE COMPL	
152027		B. W	ING		04/25/	/2018	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
VIBRA HOSPITAL OF FORT WAYNE					ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805		
(X4) ID		FATEMENT OF DEFICIENCIES	1	ID	·		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	elements: a specific					
	knowledge base,	_					
		erforming procedures,					
		at integrate critical					
	-	ndards to meet the					
	-	nd achieve desired					
	outcome						
	PROCEDURE:						
	•	stablish competency					
		on the characteristics of					
	-	services provided, risk					
	assessment, frequency of occurrence and						
		2. All competency skills					
	checklists must be approved through the						
	Education Depar	tment prior to use3.					
	Leaders are respondent						
	competence of a	ll staff is assessed,					
	maintained, impi	roved, and demonstrated					
	for the duration of	of employment. 4.					
	Competency wil	l be measured against					
	established stand	lards, and during					
	designated interv	als. 5. Learning					
	activities may co	nsist of self-study					
	modules, review	of policy/procedures,					
	hands-on experie	ence with preceptor or					
	qualified observe	er. 6. Competence may					
	be established bu	it is not limited to any of					
	the following: a	. Performance,					
	knowledge or sk	ills observed, verified,					
	and evaluated by	a qualified observer,					
	preceptor, or edu	icator. b. Observation of					
		ent performance. c.					
		Testing9. Staff					
	assignments are	based on their education,					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
152027		152027	B. W	ING		04/25/	2018	
NAME OF PROVIDER OR SUPPLIER VIBRA HOSPITAL OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT 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)	TE	(X5) COMPLETION DATE	
	experience, licenter current competer current competer certain competer established may responsibilities in appropriate super 2. Job description of officer - LTAC Care]" last reviewind indicated the following summaking tructures and facilitating the analysis and clinical service leadership role in making structures and facilitates constaff, appropriates and clinical programmation. Assures appropriates and clinical programmation of the patients. Physicians to add and enhance pating Promotes the faction involvement and and internal activates services. Posupervises the faction of the patients, where the faction of the patients of the patients of the patients. Purpose the faction of the patients of the patients, where the faction of the patients of the patients of the patients. Posupervises the faction of the patients of the patients. Posupervises the faction of the patients of the pat	isure and assessment of ince. 10. Staff for whom incies have not been be assigned patient care in that area when invision is available" In titled "Chief Clinical [Long Term Acute wed/revised 5/2017] Ilowing: POSITION esponsible for directing the activities of nursing inces. Assumes an active in the hospital's decision and process. Ensuring incestaffing for patient care, the prince of the clinical estaffing for patient care, the prince of the acuity works closely with direct systems. In the prince of the acuity works closely with direct staff for the acuity works closely with direct systems. In the prince of the clinical extent care systems. In the prince of the clinical extent care systems. In the prince of the clinical extent care systems. In the prince of the clinical extent care systems. In the prince of the clinical extent care systems. In the prince of the clinical extent care systems. In the prince of the clinical extent care systems. In the prince of the clinical extent care in the prince of the prince of the clinical extent care in the prince of the prin						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION G 00	COMP	(X3) DATE SURVEY COMPLETED 04/25/2018			
NAME OF PROVIDER OR SUPPLIER VIBRA HOSPITAL OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APP	ILD BE	(X5) COMPLETION DATE		
	following: POSResponsible for management, an service activities working shift, in established philo policies of the ho works with empl managers to dev procedures neces and provides trai support to solve accomplished as POSITION SUP RESPONSIBILI Nurses and NursJOB FUNCTION development of employees in con Educator" 4. Job description Nurse - LTAC" 2/2017 indicated POSITION SUN components of the include demonst competence; ma improving qualit professional skill	AC" last d 2/2015 indicated the ITION SUMMARY: or personnel, d coordination of nursing for the scheduled accordance with osophy, objectives and ospital. The supervisor loyees and other elop systems and ssary for daily operations, ining, information and problems and signed objectives. DERVISORY TIES: Supervises: Super						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027			A. BUILDING 00 B. WING		COMPLETED 04/25/2018				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
VIBRA HOSPITAL OF FORT WAYNE					ANDALLIA DRIVE 5TH FLOOR VAYNE, IN 46805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
	and developing of specialty"	clinical expertise per							
	on 4/24/18 at 5:2 following: The patient was 2055 hours and 6 wean on 3/29/18 "Nursing ICU Admission Asses 03/27/2018 TimeComment: AR GROIN, LINE Z WAVE FORM, NS [Normal Salis "Patient Care"	[Intensive Care Unit] ssmentDate: e: 20:56 [hours] T LINE IN RIGHT EERO AND GOOD PRESSURE BAG ON ne] 500 ML BAG" Notes3/29/18 11:10 Artial [Arterial] line is							
	N7, N8, N9 and Nurses) personne transcripts begin p.m. with A4 (H Manager) and A lacked document competencies releducation. 7. During an int Clinical Officer)	8 (Nurse Educator) tation of any completed lated to arterial line erview with A3 (Chief on 4/24/18 at 11:15							
	-	cated the facility admits CC (peripherally inserted							

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
152027		B. WING		04/25/2018				
NAME OF PROVIDER OR SUPPLIER VIBRA HOSPITAL OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT 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)	TE	(X5) COMPLETION DATE	
	peripheral lines. does not admit p and has not adm	lines, central lines, and A1 indicated the facility atients with arterial lines itted patients with ing the time period of						
	Supervisor) on 4 he/she indicated patients with arte has had one arter and it was appro	erview with N2 (Unit /24/18 at 1:45 p.m., the unit currently had no erial lines. N2 indicated rial line in the last year ximately 2 months ago. patient with the arterial d with it.						
	4/24/18 at 3:00 p facility typically with an arterial l always ask that i addressed prior t A8 indicated he/ couple of weeks expired that ther with an arterial l problem and he/s	erview with A8 on o.m., she indicated the does not accept patients ine. Facility normally t is discontinued or to arrival to the facility. She had just found out a ago after the patient had the was a patient admitted ine. A8 verified it was a she had not verified the inpetency related to the						
	4/24/18 at 3:05 p facility has the c	nterview with A3 on o.m., he/she indicated the apabilities and re for a patient with an						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152027		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/25/2018				
NAME OF PROVIDER OR SUPPLIER VIBRA HOSPITAL OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805					
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	unaware there w with an arterial l mentioned in the at 3:00 p.m. A3 not accept patier	eir interview on 4/24/18 verified the facility does ats with an arterial line.						
	Marketing Offic p.m., he/she indi	nterview with A5 (Chief er) on 4/24/18 at 3:10 cated they were unaware dmitted with an arterial						
	4/24/18 at 3:15 parterial line train not part of the ardepartment spectraining/compete (High Ops Unit) HOU departmen	-						
	applicable) beca accept patients v it did not apply. informed of a pa with an arterial l ago in an inform unable to state th	arked it N/A (not use the facility did not with arterial lines and so A8 indicated he/she was tient who was admitted ine a couple of weeks all meeting. A8 was ne date, who was in the the meeting was about.						
		nterview with A7 n Registered Nurse) on						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
152027		B. WING		04/25/2018	
NAME OF P	PROVIDER OR SUPPLIER	3		T ADDRESS, CITY, STATE, ZIP CODE RANDALLIA DRIVE 5TH FLOC	DR .
VIBRA H	OSPITAL OF FOR	ΓWAYNE	FOR	Γ WAYNE, IN 46805	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
IAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE
		p.m., he/she indicated			
		tient #2 had a femoral			
		/she indicated they do not			
		ns orders prior to			
	· ·	loes notify the physician.			
	A7 verified Faci				
		cients with arterial lines,			
		e not trained on them and			
	arterial lines are	-			
		A7 indicated he/she was a			
		cility #2 prior to taking			
	the position of C	Clinical Liaison.			
	14. During an ii	nterview with A8 on			
	4/25/18 at 3:30 j	o.m., he/she verified			
	nursing staff are	not provided arterial line			
	training/education	on because the facility			
	does not admit patients with arterial lines.				
	15. During an interview with A3 on				
	4/25/18 at 7:45 p.m., he/she verified				
	1	ical record that the			
	_	terial line while inpatient			
	at the facility.	The films inpation			

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