STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152027	A. BUILDING 00 B. WING	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF FORT WAYNE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 0000 Bldg. 00	The visit was for investigation of one Federal hospital complaint. Complaint Number: IN00253605 Substantiated: Deficiency related to the allegations is cited. Unrelated deficiencies cited. Survey Date: 3/6-7/18 Facility Number: 012132 QA: 3/22/18	A 0000		
A 0117 Bldg. 00	482.13(a)(1) PATIENT RIGHTS: NOTICE OF RIGHTS A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. Based on document review and interview, the facility failed to ensure the Notice of Patient Rights was provided to each patient or their representative for 2 of 9 medical records (MR) reviewed (Patients #2 & 6). Findings include:	A 0117	**A-117** The Admissions department reviewed process regarding Admission paperwork internally and with nursing. Nursing is responsible for Inpatient consent and DNR, Admissions or Case Management is responsible for Patient	03/19/2018

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

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	1. Review of the policy/procedure Admission Process (revised 2-18) indicated the following: "The essential elements in the admissions process include... providing a complete admissions documentation package to the patient and/or legal representative and obtain the necessary signatures... The required Inpatient Admissions Forms are... iii. Patient Rights and Responsibilities..." 2. Review of the MR document titled Acknowledgement of Receipt of Health Care Information for Patients #2 and #6 lacked documentation indicating a copy of the Patient Rights and Responsibilities had been provided to the patient or their representative and signature of receipt obtained by a facility staff. 3. On 3-7-18 at 1430 hours, the Chief Clinical Officer, staff A3 confirmed the MR for Patients #2 and #6 lacked documentation indicating the notice of Patient Rights and Responsibilities was provided and signature obtained at the time of registration.		Rights and Responsibilities. Prevent: Admissions department to review daily for completion of admission consent documentation. Responsible Party: Admission Manager Goal: 100% completion of admission paperwork within 48 hours and reviewed for 3 months Audit results will be reported to QAPI, MEC and Governing Board committees. **Expected date of completion is:** 03/19/18	
A 0286 Bldg. 00	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for			

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	which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.			
	Based on document review and interview, the facility failed to follow its policy/procedures for documenting and reviewing an adverse patient event for 1 of 7 patient events (Patient #1) reviewed. Findings include: 1. Review of the policy/procedure Risk Management Plan (revised 12-16) indicated the following: "All unusual occurrences are to be reported by employees through the online reporting system Q Solutions...an unusual occurrence report must be completed before the end of the shift... if the	A 0286	**A-286** 1. The Director of Quality and Risk Management re-educated the Leadership Team during QAPI regarding patient incident entry into Q-solutions. 2. Instructions on Q-solution entry provided to the Leadership team. 3. Q-solutions incident Reporting reviewed with leadership. Prevent Reoccurrence: Director of Quality educated leadership team at monthly QAPI meeting Q-solutions power point sent out	03/19/2018

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	occurrence involves a patient, objective clinical observations and actions taken... are precisely documented in the medical record..." 2. Review of the MR for Patient #1 on 2-5-18 indicated the patient reported not feeling "right" and was observed to be lethargic, drowsy and pale for a significant part of the day. The MR indicated the patient was observed by their Registered Nurse, staff N11 and evaluated on several occasions by the Physician MD11 for a change in status before Narcan (naloxone) was administered by IV route with immediate arousal and agitation noted. 3. Review of incident reports for the period around 2-5-18 failed to indicate an event involving Patient #1. 4. On 3-7-18 at 1115 hours, the Director of Pharmacy, staff A7 confirmed that no medication incident or ADR (adverse medication reaction) of the event on 2-5-18 involving Patient #1 had been submitted or reviewed. 5. On 3-7-18 at 1430 hours, the Chief Clinical Officer, staff A3 confirmed that no incident report documentation for the event involving Patient #1 was available.		to nursing supervisors and department leaders to review with their staff on 2/22/2018. Goal: 100% review of Q-solutions incidents reported with unusual occurrences for 3 months. Audit results will be reported to QAPI, MEC and Governing Board Responsible Party: Chief Clinical Officer **Expected date of completion is:** 03/19/18	

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A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based upon document review and interview, the Registered Nurse failed to supervise and evaluate the care provided to each patient for 1 of 9 medical records (MR) reviewed (Patient #1). Findings include: 1. Review of the policy/procedure Medical Records Documentation Requirements (revised 12-16) indicated the following: "All medical records will contain documentation to substantiate care and treatment provided." 2. Review of the MR for Patient #1 indicated the following orders on 1-20-18 at 2100 hours: "alternate foot drop boot every two hours." 3. Review of the MR for Patient #1 lacked documentation indicating the foot drop boot was removed from one foot and placed on the alternate foot every two hours. 4. On 3-7-18 at 1430 hours, the Chief Clinical Officer, staff A3 confirmed the MR lacked documentation indicating the foot drop boot was removed and replaced	A 0395	**A-395** 1. Nursing staff educated on documentation for all patient care including condition changes. 2. Documentation should be current and reflect all care provided to patients Prevent Reoccurrence: HIM and Nursing Leadership review clinical documentation monthly. Clinical audits began on February 1, 2018. Responsible Party: Chief Clinical Officer Goal: 100% documentation of worklist orders. Reviewed for 3 months. Audit results will be reported to QAPI, MEC and Governing Board committees. Responsible Party: Chief Clinical Officer **Expected date of completion is:** 03/07/18	03/07/2018

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	as ordered.			
S 0000 Bldg. 00	The visit was for investigation of one State hospital complaint. Complaint Number: IN00253605 Substantiated: Deficiency related to the allegations is cited. Unrelated deficiencies cited. Survey Date: 3/6-7/18 Facility Number: 012132 QA: 3/22/18	S 0000		
S 0102 Bldg. 00	410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a) (a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on document review and interview, the facility failed to ensure the Notice of Patient Rights was provided to each patient or their representative for 2 of 9 medical records (MR) reviewed (Patients #2 & 6).	S 0102	1. - 3. The Admissions department reviewed process regarding dmission paperwork internally and with nursing. Nursing is responsible for Inpatient consent and DNR,	03/08/2018

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	Findings include: 1. Review of the policy/procedure Admission Process (revised 2-18) indicated the following: "The essential elements in the admissions process include... providing a complete admissions documentation package to the patient and/or legal representative and obtain the necessary signatures...The required Inpatient Admissions Forms are... iii. Patient Rights and Responsibilities..." 2. Review of the MR document titled Acknowledgement of Receipt of Health Care Information for Patients #2 and #6 lacked documentation indicating a copy of the Patient Rights and Responsibilities had been provided to the patient or their representative and signature of receipt obtained by a facility staff. 3. On 3-7-18 at 1430 hours, the Chief Clinical Officer, staff A3 confirmed the MR for Patients #2 and #6 lacked documentation indicating the notice of Patient Rights and Responsibilities was provided and signature obtained at the time of registration.		Admissions or Case Management is responsible for Patient Rights and Responsibilities. Prevent Reoccurrence: Admissions department to review daily for completion of admission consent documentation. Responsible Party: Admission Manager Monitoring: # of Patients with correct admission paperwork complete including Patient Rights/ # of patients in admitted to the hospital Goal: 100% completion of admission paperwork within 48 hours and reviewed for for 3 month. Audit results will be reported to QAPI, MEC and Governing Board committees.	
S 0418 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2)			

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	(b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows: (1) The action shall be documented. (2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care. Based on document review and interview, the facility failed to follow its policy/procedures for documenting and reviewing an adverse patient event for 1 of 7 patient events (Patient #1) reviewed. Findings include: 1. Review of the policy/procedure Risk Management Plan (revised 12-16) indicated the following: "All unusual occurrences are to be reported by employees through the online reporting system Q Solutions... an unusual occurrence report must be completed before the end of the shift... if the occurrence involves a patient, objective clinical observations and actions taken... are precisely documented in the medical record..." 2. Review of the MR for Patient #1 on 2-5-18 indicated the patient reported not	S 0418	1. The Director of Quality and Risk Management re-educated the Leadership Team during QAPI regarding patient incident entry into Q-solutions. 2. Instructions on Q-solution entry provided to the Leadership team. 3. - 5. Q-solutions incident reporting reviewed with leadership. **Prevent Reoccurrence:** Director of Quality educated leadership team at monthly QAPI meeting inJanuary and February. Q-solutions power point sent out to nursing supervisors and department leaders to review with their staff on 2/22/2018. **Responsible Party:** **Chief Clinical Officer** **Monitoring:** **# of Patients with unusual occurrences documented in Q-solutions / # of unusual occurrences reported** **Goal:** **100% review of Q-solutions incidents reported with unusual occurrences for 3**	03/08/2018

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	feeling "right" and was observed to be lethargic, drowsy and pale for a significant part of the day. The MR indicated the patient was observed by their Registered Nurse, staff N11 and evaluated on several occasions by the Physician MD11 for a change in status before Narcan (naloxone) was administered by IV route with immediate arousal and agitation noted. 3. Review of incident reports for the period around 2-5-18 failed to indicate an event involving Patient #1. 4. On 3-7-18 at 1115 hours, the Director of Pharmacy, staff A7 confirmed that no medication incident or ADR (adverse medication reaction) of the event on 2-5-18 involving Patient #1 had been submitted or reviewed. 5. On 3-7-18 at 1430 hours, the Chief Clinical Officer, staff A3 confirmed that no incident report documentation for the event involving Patient #1 was available.		**months. Audit results will be reported to QAPI, MEC and Governing Board**	
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			

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	and evaluate the care planned for and provided to each patient. Based upon document review and interview, the Registered Nurse failed to supervise and evaluate the care provided to each patient for 1 of 9 medical records (MR) reviewed (Patient #1). Findings include: 1. Review of the policy/procedure Medical Records Documentation Requirements (revised 12-16) indicated the following: "All medical records will contain documentation to substantiate care and treatment provided." 2. Review of the MR for Patient #1 indicated the following orders on 1-20-18 at 2100 hours: "alternate foot drop boot every two hours." 3. Review of the MR for Patient #1 lacked documentation indicating the foot drop boot was removed from one foot and placed on the alternate foot every two hours. 4. On 3-7-18 at 1430 hours, the Chief Clinical Officer, staff A3 confirmed the MR lacked documentation indicating the foot drop boot was removed and replaced as ordered.	S 0930	1. Nursing staff educated on documentation for all patient care including condition changes. 2. - 4. Documentation should be current and reflect all care provided to patients. **Prevent Reoccurrence:** **HIM and Nursing Leadership review clinical documentation monthly. Clinical audits began on February 1, 2018.** **Responsible Party:** **Chief Clinical Officer** **Monitoring:** **# of orders with correct nursing** documentation / # of orders on worklist **Goal:** **100% documentation of worklist orders. Reviewed for 3 months. Audit results will be reported to QAPI, MEC and Governing Board committees.**	03/08/2018