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

FORM APPROVED
OMB NO. 0938-0391

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	05/31/2018

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

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S 0000 Bldg. 00	This visit was for the investigation of one (1) state complaint. Complaint Number: IN00263213 Substantiated; Deficiency related to allegation cited. Date of survey: 5/30/18 and 5/31/18 Facility number: 012132 QA: 6/25/18	S 0000		
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 5 of 10 patients. (patients #2, 4, 6, 7 and 9) Findings include; 1. Facility policy titled "Change in Condition" last reviewed/revised 12/2016 indicated the following: " ...POLICY: ...Any single finding does describe a significant change in condition and requires Assessment, Documentation and Notification. ...New onset arrhythmia: Atrial fibrillation, runs of V-tachycardia, 2-3rd Degree	S 0930	The following plan of correction is intended to demonstrate the facility's commitment to compliance with applicable state and federal regulations. The statements set forth below shall not be construed as an admission or constitute agreement with the deficiencies alleged. The facility has taken or will take the actions set forth in the following plan of correction by the dates indicated.	08/03/2018

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

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.

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	block ...Acute chest pain ...Change in BP [blood pressure] from baseline that is not intended by therapeutic intervention. Any BP < [less than] 90 systolic, > [greater than] 180 systolic ...Acute onset of pain: Change in patient's baseline pain pattern, i.e. - no relief from previous effective interventions or escalation in the rating of the pain on the scale. PROCEDURE: Upon recognition of change in condition a Rapid Response Team will be called (See Rapid Response Team Policy). A complete head to toe assessment by a Registered Nurse along with consultation as appropriate among the clinical team. It is the responsibility of the supervisor to ensure that the process to assess the patient occurs in a timely fashion, and to gather relevant data ...Data to obtain includes but is not limited to: A complete set of vital signs including accurate temp. [Temperature] A rhythm strip. Pulse ox reading. Finger stick glucose. A complete pain assessment ....Notification: (use SBAR [Situation, Background, Assessment and Recommendation] format to communicate all critical information). It is the Supervisors responsibility to ensure that the house officer or attending physician is notified in a timely manner ...Documentation: The complete assessment should appear in the Electronic Medical Record (EMR) or Nursing flowsheet for those hospitals not on EMR. The SBAR form will be used to document communication about the patient to the MD and will be placed in the progress notes section of the medical record ...." 2. Facility policy titled "Pain Assessment and Management" last reviewed 11/2016 indicated the following: POLICY: Management of a patient's pain includes individualized assessment, intervention, and evaluation of pain and pain relief. A patient's self report of pain will be accepted as the most reliable indicator of pain. ...PROCEDURE: 1. Assessment: Assessment		**S 930** 1. The Nurse Manager/Chief Clinical Officer will provide the nurses with education and training regarding assessments of patients with a change in medical condition, the requirement for the RN to supervise and evaluate the nursing care for each patient and complete an RN assessment for each patient. 2. Training will be completed by August 3, 2018. 3. The Nurse Manager/Chief Clinical Officer will conduct weekly audits on an ongoing basis for the next four (4) months, starting on 7/23/18, to ensure 100% compliance with an RN assessment. 4. The Nurse Manager/Chief Clinical Officer will submit findings of weekly reviews to the Director of Quality and report on results at the Quality Assessment & Performance Improvement Committee and the Medical Executive Committee. 5. The Nurse Manager/Chief Clinical Officer will provide the nursing staff with training/education on the Rapid Response Team Policy, with emphasis on documentation and notification to the physician for any changes of patient's medical condition. 6. Training will be completed by August 3, 2018. 7. The Nurse Manager/Chief	

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	criteria used to determine patient care needs may include clinical presentation, diagnostic testing, patient interview, the patient's past experience with pain, and information obtained from family ...Patients are assessed for pain at the Hospital on admission and then reassessed at least every shift. Determining the location of pain. Determining the intensity of pain. Determining the duration of pain. Determining the onset of pain. Determining the aggravating and alleviating factors. Utilization of the Pain Rating Scale. Patients that are administered pain medications will be reassessed within 1 hour of administration. Follow-up documentation includes a reassessment of the numeric pain intensity scale. Pain assessments are conducted using a numeric pain intensity scale where patients are asked to rate their pain on a scale from 0 to 10. The assessment includes a descriptive scale to match the numeric pain intensity scale. A visual analog scale or a graduated facial expressions scale (Wong-Baker FACES) may be utilized for pain assessment as well ...For administration of pain medications the following pain scale interpretation is utilized: 1-3 mild pain. 4-7 moderate pain. 8-10 severe pain. 2. Intervention: Pharmacological and non-pharmacological interventions may be used to treat a patient's pain ...." 3. Review of patient #2's medical record indicated the following: (A) The patient was admitted on 5/14/18 at 1651 hours and transferred to facility #2 Emergency Department on 5/18/18 at 0445 hours. Admit diagnoses included but were not limited to acute on chronic diastolic congestive heart failure, acute on chronic respiratory failure with hypoxia and hypercapnia and chronic atrial fibrillation. (B) The patient had physician order dated 5/14/18 at 1646 hours for		Clinical Officer will conduct weekly audits on an ongoing basis for the next four (4) months, starting on 7/23/18, to ensure 100% compliance with documentation and notifications to physicians as needed. 8. The Nurse Manager/Chief Clinical Officer will submit findings of weekly reviews to the Director of Quality and report on results at the Quality Assessment & Performance Improvement Committee and the Medical Executive Committee. 9. The Nurse Manager/Chief Clinical Officer will provide the nursing staff with training/education on the Pain Assessment and Management Policy. 10. Training will be completed by August 3, 2018. 11. The Nurse Manager/Chief Clinical Officer will conduct weekly audits on an ongoing basis for the next four (4) months, starting on 7/23/18, to ensure 100% compliance with documentation of pain assessment and management. 12. The Nurse Manager/Chief Clinical Officer will submit findings of weekly reviews to the Director of Quality and report on results at the Quality Assessment & Performance Improvement Committee and the Medical Executive Committee.	

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	hydrocodone-acetaminophen 5-325 milligrams, one tablet by mouth every six hours as needed for pain level 1-5 with a start date of 5/14/18 at 1644 hours and an end date of 5/16/18 at 0916 hours. The patient had a physician order dated 5/14/18 at 1646 hours for hydrocodone-acetaminophen 5-325 milligrams, two tablets by mouth every six hours as needed for pain level 6-10 with a start date of 5/14/18 at 1644 hours and a discontinue date of 5/16/18 at 0916 hours. The patient had a physician order dated 5/16/18 at 0917 hours for tramadol 50 milligrams by mouth every six hours as needed for moderate pain (pain score 4-6) severe pain (pain score 7-10) with a start date of 5/16/18 at 0917 hours and a discontinue date of 5/18/18 at 0916 hours. The patient had a physician order dated 5/18/18 at 0133 hours for hydrocodone-acetaminophen 10-325 milligrams one tablet by mouth every four hours as needed for moderate pain (pain score 4-6) severe pain (pain score 7-10) with a start date of 5/18/18 at 0131 hours and discontinue date of 5/18/18 at 0916 hours. The patient had a physician order dated 5/18/18 at 0359 hours for nitroglycerin 0.4 milligrams sublingual one tablet every five minutes as needed for chest pain times three doses with a with a start date of 5/18/18 at 0356 hours and discontinue date of 5/18/18 at 0916 hours. (C) The patient care note dated 5/15/18 at 0818 hours indicated a pain level of 8/10 located in left shoulder. The medical record lacked PRN (as needed) pain medication administration and pain level reassessment. (D) The patient vital signs flowsheet indicated on		Person responsible for all above plans of correction is the Chief Clinical Officer. Expected date of completion for all training is August 3, 2018	

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	5/17/18 at 1600 hours the patient's blood pressure was 89/69. A patient care note dated 5/17/18 at 1631 hours indicated "BP [blood pressure] LOW PULSE 68 ...." The medical record lacked documentation of a blood pressure reassessment or physician notification of the low blood pressure. (E) The Nursing shift assessment flowsheet dated 5/17/18 at 2313 hours indicated the patient complaint of constant pain aggravated by movement with pain relief measures of medication and reposition. The medical record lacked pain level score assessment, PRN pain medication administration and pain level reassessment. The next documented PRN pain medication administered was tramadol 50 milligrams by mouth on 5/18/18 at 0030 hours for a pain level score of 9/10. The medical record lacked pain location, pain intensity and pain level reassessment. (F) The medication administration record (MAR) indicated hydrocodone-acetaminophen 10/325 milligrams one tablet by mouth on 5/18/18 at 0134 hours. A patient care note dated 5/18/18 at 0730 hours indicated the following: " ...Pt. [patient] stated [he/she] was having severe pain at approximately 0030 [hours] NP [Nurse Practitioner] on call was contacted by this nurse and Norco 10-325 [milligrams] was ordered and given for pain that was a 9/10. Pt was rechecked at 0130 [hours] and stated pain was 6/10. The medical record lacked documentation of pain location, pain intensity and unable to determine pain level pre and post pain medication administration. (G) A patient care note by A12 (Registered Nurse) dated 5/18/18 at 0730 hours indicated the following: " ...At 0230 [hours] the pt put the call			

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	light on and stated [he/she] couldn't breathe. RT [Respiratory Therapy] was called and breathing tx [treatment] was done. Pt put light on again at 0330 [hours], ...RT went in with this nurse and pt stated [he/she] could not breathe and "I'm having a heart attack" This nurse had RT go get EKG [electrocardiogram] machine I then asked "Have you ever had one?" Pt stated "TWO" I then called charge supervisor RN [Registered Nurse] [A15]. EKG was obtained at 0338 [hours] and NP on call was notified of change in comparison to baseline at 0339 [hours] NP ordered Tropinon [Troponin] to be drawn and EKG to be done and Nitro [Nitroglycerin] to be given. Access was infiltrated in pts L [left] antecubital and IV [intravenous] access was attempting to be made when NP was recalled at 0425 [hours] by Nurse supervisor and explained in an overly calm voice situation. When conversation was over the supervisor stated NP wanted to wait on the PICC team to come and gain access. This nurse then walked out of the pts room and went to nurse's station and called NP herself and stated that the urgency of the situation was not being conveyed that the pts status had drastically changed within the past hour and that IV access wasn't able to be obtained ...I was given permission to transfer at 0445 [hours] and called ER [Emergency Room] and pt was taken off the floor at 0449 ...." The medical record lacked documentation of patient head to toe assessments, a complete set of vitals which included blood pressure, temperature, pain level, pain location, pain intensity, aggravating and alleviating factors, glucose fingerstick, documentation of an SBAR form, administration of nitroglycerin as ordered, who, when, how much nitroglycerin was administered and vital assessments, including pain level before and after administration of nitroglycerin, therefore was unable to verify nitroglycerin was admisnistered as ordered.			

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	4. Review of patient #4's medical record indicated the following: (A) The patient had an admit diagnosis of unspecified fracture of sacrum. (B) A pain level of 6/10 located at sacrum and lower back on 5/15/18 at 1845 hours. " ...No position is comfortable while in bed and Patient keeps moving around from side to side." PRN (as needed) Hydrocodone-Acetaminophen 5/325 milligrams by mouth was administered on 5/15/18 at 1841 hours. The medical record lacked documentation of pain level reassessment, which would determine need for additional pain management interventions. 5. Review of patient #6's medical record indicated the following: (A) The patient had an admit diagnosis of infection/inflammatory reaction due to internal right hip prosthesis. (B) The patient's admission assessment on 5/19/18 at 1720 hours indicated a pain level of 7/10 located at right hip, sharp, aching, aggravated by activity and pain relief measures was indicated as medication. A general comment in the admission assessment located under admitting vital signs indicated the following: "CHARGE NURSE TAKING CARE OF MEDICATING PT [patient] FOR PAIN." The medical record lacked documentation of pain medication administration and pain level reassessment for 5/19/18 at 1720 hours, which would determine need for additional pain management interventions. (C) A pain level of 8/10 on 5/28/18 at 0815 hours. The medical record lacked documentation of pain location, pain medication administration and pain level reassessment, which would determine need for additional pain management interventions.			

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(D) A nurse note dated 5/30/18 at 1540 hours indicated a pain level of 9/10 to the right hip. PRN Tramadol 50 milligrams by mouth was administered at 1532 hours. The medical record lacked documentation of a pain level reassessment, which would determine need for additional pain management interventions.

6. Review of patient #7's medical record indicated the following:
(A) The patient had an admit diagnosis of acute and chronic respiratory failure with hypoxia.
(B) A pain level of 7/10 and the administration of PRN pain medication hydrocodone-acetaminophen 5-325 milligrams, one tab by mouth on 5/24/18 at 2218 hours. The medical record lacked documentation of pain level intensity, pain location and pain level reassessment, which would determine need for additional pain management interventions.
(C) A pain level of 8/10 and the administration of PRN pain medication hydrocodone-acetaminophen 5-325 milligrams, one tab by mouth on 5/30/18 at 1706 hours. The medical record lacked documentation of pain level intensity, pain location and pain level reassessment, which would determine need for additional pain management interventions.

7. Review of patient #9's medical record indicated the following:
(A) The patient had an admit diagnosis of acute respiratory failure.
(B) The PRN pain medication tramadol 50 milligrams was administered via peg (percutaneous endoscopic gastrostomy) tube on 5/24/18 at 0929 hours. The medical record lacked

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	documentation of pain level, pain location, pain intensity prior to administration of PRN pain medication and a pain level reassessment by nursing staff, which would determine the need for additional pain management interventions. (C) A pain level score of 8/10 located at right lower extremity on 5/24/18 at 1026 hours was documented by A11 (Physical Therapist Assistant). The medical record lacked documentation of a pain level reassessments by nursing staff, which would determine need for additional pain management interventions. 8. During an interview with A2 (Chief Clinical Officer) on 5/31/18 at 10:44 a.m., he/she verified that a cardiac rapid response team was initiated for patient #2 and there should have been a rapid response team record completed. He/she also verified the Nurse Supervisor is ultimately responsible to complete the rapid response team record and place it in the patient's medical record. 9. During an interview with A2 on 5/31/18 at 11:05 a.m., he/she verified the medical record information for patient #2. He/she verified a patient's pain level was to be reassessed within an hour of by mouth pain medication administration. A2 also indicated patient #2's blood pressure of 89/69 on 5/17/18 at 1600 hours, should have been reassessed within an hour and if there was no change, notify the physician. 10. During an interview on 5/31/18 at 11:55 a.m., A8 (Pharmacist) verified that one bottle of Nitroglycerin 0.4 milligrams sublingual was pulled from "Med Dispense" on 5/18/18 at 0400 hours by A15 (Nurse Supervisor) and A12 (Registered Nurse) as an override. He/she also verified the order for Nitroglycerin 0.4 milligrams sublingual PRN chest pain one every five minutes PRN times three doses was entered into the			

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	system by A15 on 5/18/18 at 0359 hours. 11. During medical record review with A2 on 5/31/18 at 1:05 p.m., he/she verified the medical record information of patient #4. 12. During medical record review with A2 on 5/31/18 at 2:20 p.m., he/she verified the medical record information of patient #6. 13. During medical record review with A9 (Registered Nurse) on 5/31/18 at 3:12 p.m., he/she verified the medical record information of patient #7. 14. During medical record review with A9 on 5/31/18 at 4:45 p.m., he/she verified the medical record of patient #9.			