PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391

	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	22	TREET ADDRESS, CITY, STATE, ZIP CODE 200 RANDALLIA DRIVE 5TH FLOOR ORT WAYNE, IN 46805 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	BE COMPLETION
VIBRA HOS (X4) ID PREFIX TAG	SPITAL OF FORT WAY SUMMARY S (EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
A 000		S			
	This visit was for in		A 000		
A 115	hospital Immediate Immediate Jeopardy Conditions of Patien compliance. The IJ von 2/14/18. Complaint Number: Substantiated: deficiallegations are cited Date: 2/14/18 Facility Number: 01 QA: 2/16/18 PATIENT RIGHTS CFR(s): 482.13	was not removed prior to exit IN00254140 ciencies related to the	A 115		
	patient's rights. This CONDITION is Based on document observation, the fact could participate in the implementation of the provision of information the patient could unfacility failed to ensure presentative had the decisions (see tag American patient had the safe setting (see tag ensure patient had the safe setting the safe setting (see tag ensure patient had the safe setting the safe	s not met as evidenced by: at review, staff interview and ility failed to ensure patient the development and heir plan of care due to lack of tion in language and terms derstand (see tag A 130), the her patient or his or her the right to make informed (131), the facility failed to he right to receive care in a he (2414), the facility failed to he right to be free from all he tag A145), the facility failed			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

03/07/2018

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		152027	B. WING		C 02/14/2018
	ROVIDER OR SUPPLIER SPITAL OF FORT WAYN	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	02/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
A 115	mental abuse and/or facility failed to ensur patient's plan of care A166), the facility fail written by a physicial independent practition restraints (see tag Arensure the attending restraint use (see tag ensure a time limit for new order for restraint (see tag A171), the face tag A171), the face tag A171), the face tag A172), the face tag A 172), the face tag A 1	nts to be free from physical or restraint (see tag A154), the re the modification of the with use of restraint (see tag led to ensure an order was nor other licensed oner prior to the use of 168), the facility failed to physician was notified of QA170), the facility failed to or use of restraint and that a nt was written after 24 hours acility failed to ensure after to-face assessment by the dindependent practitioner ting a new order for restraint facility failed to ensure estrictive interventions were use of restraint (see tag led to document rationale for straints (see tag A188). Cut of these systemic the hospital's inability to Rights were promoted. ARTICIPATION IN CARE	A 1:		
	observation, the facil could participate in the	ity failed to ensure patient			

		(X3) DATE COMP	SURVEY				
		152027	B. WING				C 44/2048
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	1 02/	14/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 130	the patient could under patient medical record patient medical record. Findings: 1. Policy titled, "Suspabuse/Neglect", revisindicated on pg. 2, pobut is not limited to I specialized needs of patient". 2. Policy titled, "Culturevised/reapproved 1 under Procedure sect communication approneeds. See leadershit Communication". 3. Facility lacked a ptranslation communication approneeds. See leadershit	on in language and terms erstand for 1 of 10 (#1) ds reviewed (MR). Dected Patient edd/reapproved 12/16, bint 5.M., "Neglect includes Failure to accommodate the the disabled or elderly Ural Competency Diversity", 1/17, indicated on pg. 2, tion, bulleted point, "Modify baches to meet cultural p policy on Translation Olicy/procedure related to ation. Immedical records on 2/14/18 1 hours indicated, patient 1 o presented to the facility on rs for complex medical stage renal disease, e. 1, and encephalopathy. Dicated patient does not w of systems and family to be obtained due to patient eaking. Physician Order of hours indicated Speech one daily with Spanish and rehab swallow study	A	130			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LTIPLE CONSTRUCTION (X3) DATE S COMPL	
		152027	B. WING		C 02/14/2018
	ROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	1 02/14/2010
(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 CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE COMPLETION
A 130	staff 7 (Speech Lang at 1906 hours and a MR lacked documer provided in Spanish dated 2/3/18 indicate commands in Spanish that staff provided tr patient. This patient this facility. 5. Staff 7 (Speech Linterviewed on 2/14/hours and confirmed A. Daily speech th with Spanish langual dysphagia swallows member on 1/31/18 1/3/18 at 1828 hours provided to patient in B. a barium swallo 2/21/18, but there is instructions to be proceed to the staff member on 1/31/18 at 1828 hours provided to patient in B. a barium swallo 2/21/18, but there is instructions to be proceed to the staff member on 1/31/18 at 1828 hours provided any educar Spanish for medical 6. Staff 8 (R.N.) was approximately 1705 asked how he/she context the staff 8 (R.N.) was approximately 1705 asked how he/she context the staff 8 stated they have staff 8 staff 8 stated they have staff 8 staff 8 stated they have staff 8 staff 8 staff 8 staff 8 staff 8 staff 8 stated they staff 8	swallow study was done by guage Therapist) on 1/31/18 gain on 1/3/18 at 1828 hours. Intation of instructions being Physician Progress Note ed patient "will follow sh". MR lacks documentation anslation services to this is currently an inpatient at a sanguage Therapist) was 18 at approximately 1618 lieurapy was not being done ge assistance. A bedside study was done by this staff at 1906 hours and again on and instructions were not in Spanish. In Spanish, we study is going to be done no process in place for evided in Spanish, but has apporting this and has not a since the study was done by the staff at 1906 hours and again on some same instructions were not in Spanish. In Spanish, but has apporting this and has not stion courses related to professionals.	A 13		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			TE SURVEY MPLETED
		152027	B. WING			C 2/14/2018
	ROVIDER OR SUPPLIER SPITAL OF FORT WAYN	IE		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805		2/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 130	Secretary), staff 11 (I staff 12 (R.N.) were i 2/14/18 at approxima nurses station. When communicated with pand said they didn't ke Cyracom language tr stated they had just I few hours ago and di When asked if they hasfety huddles since had no knowledge of services. 8. Staff 2 (Chief Cliron 2/14/18 at approx and 1700 hours, and had a swallow study hours and again on 1 was no translation secommunicate with the	Technician), staff 10 (Unit Patient Care Technician) and nterviewed together on Itely 1710 hours, at the	A 13	30		
A 131	Inpatient Care Unit, 8 accompanied by staf and patient 1 was in and making eye cont English and had a NO PATIENT RIGHTS: If CFR(s): 482.13(b)(2) The patient or his or allowed under State	f 2 (Chief Clinical Officer) room 510. He/She was alert act, but could not speak G tube (nasogastric) in place. NFORMED CONSENT	A 13	31		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL		I				
		152027	B. WING				C 14/2018
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	1 02/	14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 131	or her health status, I planning and treatme or refuse treatment. construed as a mech provision of treatmen medically unnecessa This STANDARD is I Based on document observation the facilithis or her represental informed decisions di information in langua could understand for records reviewed. Findings: 1. Policy titled, "Susp Abuse/Neglect", revisindicated on pg. 2, pour but is not limited to! specialized needs of patient". 2. Policy titled, "Culturevised/reapproved 1 under Procedure sec communication approneeds. See leadershit Communication". 3. Facility lacked a ptranslation communication 4. Review of patient at approximately 120	reclude being informed of his being involved in care nt, and being able to request This right must not be anism to demand the tor services deemed ry or inappropriate. The motion met as evidenced by: review, staff interview and y failed to ensure patient or tive had the right to make use to lack of provision of ge and terms the patient 1 of 10 (#1) patient medical seed/reapproved 12/16, bint 5.M., "Neglect includes Failure to accommodate the the disabled or elderly sural Competency Diversity", 1/17, indicated on pg. 2, tion, bulleted point, "Modify baches to meet cultural p policy on Translation olicy/procedure related to	A	131			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/SU		(X3) DATE SURVEY COMPLETED		
		152027	B. WING		C 02/14/2018
	ROVIDER OR SUPPLIER DISPITAL OF FORT WAY	'NE	2	TREET ADDRESS, CITY, STATE, ZIP CODE 200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	, 02.1.1.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	O BE COMPLETION
A 131	status, including endiabetes mellitus tyl History & Physical is speak English. Revi history were unable being non-English stated 1/30/18 at 10 Therapy was to be language assistance was okay to be don Language Therapis with instructions to bedside dysphagia staff 7 (Speech Lan at 1906 hours and at 1906 hours and at MR lacked docume provided in Spanish dated 2/3/18 indicated commands in Spanithat staff provided to	ge 6 burs for complex medical d-stage renal disease, be 1, and encephalopathy. Indicated patient does not liew of systems and family to be obtained due to patient speaking. Physician Order 30 hours indicated Speech done daily with Spanish e and rehab swallow study e if okay with Speech than Primary Care Physician be provided in Spanish. A swallow study was done by guage Therapist) on 1/31/18 again on 1/3/18 at 1828 hours. Intation of instructions being the provided in Spanish. A swallow study was done by guage Therapist) on 1/31/18 again on 1/3/18 at 1828 hours. Intation of instructions being the progress Note and patient "will follow ish". MR lacks documentation canslation services to this it is currently an inpatient at	A 131		
	interviewed on 2/14 hours and confirmed A. Daily speech the with Spanish languar dysphagia swallow member on 1/31/18 1/3/18 at 1828 hour provided to patient in B. a barium swallow 2/21/18, but there is instructions to be proceeded.	nerapy was not being done age assistance. A bedside study was done by this staff at 1906 hours and again on a sand instructions were not in Spanish. Down study is going to be done as no process in place for			

AND DI AN OF CORRECTION IN IMPER		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
		152027	B. WING			C
	ROVIDER OR SUPPLIER DSPITAL OF FORT WAYN			STREET ADDRESS, CITY, STATE, ZIP CO 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805		2/14/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
A 131	approximately 1705 hasked how he/she con he/she stated "with far gestures". When ask language translation speak with the patient staff 8 stated they has services a few hours to use it. 7. Staff 9 (Telemetry Secretary), staff 11 (Fanding 11 (Fanding 12 (Fanding 11 (Fand	interviewed on 2/14/18 at nours, and confirmed when ommunicated with patient 1 acial cues and hand ed to utilize the Cyracom services so surveyor could at who spoke only Spanish, d just learned about the ago and did not know how Technician), staff 10 (Unit Patient Care Technician) and interviewed together on tely 1710 hours, at the	A 1:	31		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED	
		152027	B. WING		02/14	/2018	
	ROVIDER OR SUPPLIER SPITAL OF FORT WAY	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	, ,	.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 131	accompanied by sta and patient 1 was in and making eye con English and had a N	5th Floor, was toured ff 2 (Chief Clinical Officer) room 510. He/She was alert tact, but could not speak IG tube in place. CARE IN SAFE SETTING	A 13				
	The patient has the setting. This STANDARD is Based on documen observation the facil had the right to rece to lack of provision of	right to receive care in a safe not met as evidenced by: t review, staff interview and ity failed to ensure patient ive care in a safe setting due of information in language and uld understand for 1 of 10					
	indicated on pg. 2, p but is not limited to specialized needs o patient". 2. Policy titled, "Cul revised/reapproved under Procedure se communication appr needs. See leaders! Communication".	ised/reapproved 12/16, point 5.M., "Neglect includes .Failure to accommodate the f the disabled or elderly tural Competency Diversity", 11/17, indicated on pg. 2, ction, bulleted point, "Modify roaches to meet cultural nip policy on Translation					
	3. Facility lacked a translation communi	policy/procedure related to ication.					

	OF DEFICIENCIES CORRECTION			DATE SURVEY COMPLETED			
		152027	B. WING			C 2/14/2018	
	ROVIDER OR SUPPLIER SPITAL OF FORT WAYN	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805		02/14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
A 144	at approximately 120 was a 61-year old wh 12/29/17 at 1954 hor status, including end diabetes mellitus typ. History & Physical in speak English. Revie history were unable to being non-English speaked 1/30/18 at 103. Therapy was to be dianguage assistance was okay to be done Language Therapist with instructions to be bedside dysphagia sit staff 7 (Speech Languated 1906 hours and as MR lacked documen provided in Spanish, dated 2/3/18 indicated commands in Spanish that staff provided trapatient. This patient in this facility. 5. Staff 7 (Speech Linterviewed on 2/14/1 hours and confirmed A. Daily speech the with Spanish languaged dysphagia swallow is member on 1/31/18 at 1828 hours provided to patient in B. a barium swallow.	medical records on 2/14/18 If hours indicated, patient 1 no presented to the facility on ars for complex medical -stage renal disease, is 1, and encephalopathy, dicated patient does not ew of systems and family to be obtained due to patient beaking. Physician Order in hours indicated Speech one daily with Spanish and rehab swallow study if okay with Speech and Primary Care Physician is provided in Spanish. A wallow study was done by uage Therapist) on 1/31/18 gain on 1/3/18 at 1828 hours. It attion of instructions being Physician Progress Note in the provided in Spanish is currently an inpatient at secure the provided in Spanish is currently an inpatient at secure the provided in Spanish in the provided in Spanish. It is a provided in Spanish in the provided in Spanish in the provided in Spanish in the provided in Spanish. It is the provided in Spanish in the provided in	A 14	14			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN			MPLETED
		152027	B. WING			C 02/14/2018
	ROVIDER OR SUPPLIER SPITAL OF FORT WAY	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805		2271-112010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 144	Continued From page	ge 10	A 1	44		
	no documentation su attended any educar Spanish for medical 6. Staff 8 (R.N.) was approximately 1705 asked how he/she che/she stated "with the gestures". When asl language translation speak with the patie staff 8 stated they have	er speaks Spanish, but has upporting this and has not tion courses related to professionals. s interviewed on 2/14/18 at hours, and confirmed when ommunicated with patient 1 facial cues and hand ked to utilize the Cyracom a services so surveyor could nt who spoke only Spanish, ad just learned about the sago and did not know how				
	Secretary), staff 11 (staff 12 (R.N.) were 2/14/18 at approxim nurses station. Whe communicated with and said they didn't Cyracom language t stated they had just few hours ago and of When asked if they safety huddles since had no knowledge of services. 8. Staff 2 (Chief Clion 2/14/18 at approximated 1700 hours, and had a swallow study hours and again on was no translation s communicate with the	y Technician), staff 10 (Unit (Patient Care Technician) and interviewed together on ately 1710 hours, at the n asked how they patient 1, they looked puzzled know. When asked about the translation services, they all learned about the services a did not know how to use it. had spoken about it in daily a 2/7/18, they all stated they of the language translation sinical Officer) was interviewed kimately 1150, 1239, 1426 did confirmed when Patient 1 of done on 1/31/18 at 1906 1/3/18 at 1828 hours there ervice available for staff to the patient. This staff member is communicated with Patient				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 11 20123			(С
		152027	B. WING			02/	14/2018
	ROVIDER OR SUPPLIER SPITAL OF FORT WAYN	IE		22	TREET ADDRESS, CITY, STATE, ZIP CODE 200 RANDALLIA DRIVE 5TH FLOOR ORT WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 144	Continued From page 1.	e 11	A	144			
A 145	Inpatient Care Unit, 5 accompanied by staff and patient 1 was in and making eye contenglish and had a NO PATIENT RIGHTS: F ABUSE/HARASSME CFR(s): 482.13(c)(3)	f 2 (Chief Clinical Officer) room 510. He/She was alert act, but could not speak G tube in place. REE FROM NT	A	145			
	This STANDARD is a Based on document observation, the facilith had the right to be fredue to lack of provision.	not met as evidenced by: review, staff interview and ity failed to ensure patient ee from all forms of abuse on of information in language t could understand for 1 of					
	indicated on pg. 2, po but is not limited to! specialized needs of patient". 2. Policy titled, "Cultr revised/reapproved 1 under Procedure sec communication appro	pected Patient sed/reapproved 12/16, bint 5.M., "Neglect includes Failure to accommodate the the disabled or elderly ural Competency Diversity", 1/17, indicated on pg. 2, tion, bulleted point, "Modify baches to meet cultural ip policy on Translation					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		152027	B. WING				C (4.4/2048	
NAME OF PROVIDER OR SUPP	 LIER	102021	1	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	02/	/14/2018	
					RANDALLIA DRIVE 5TH FLOOR			
VIBRA HOSPITAL OF FOR	T WAYNE			FOR	RT WAYNE, IN 46805			
PREFIX (EACH D	EFICIENCY MUS	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE	
A 145 Continued Fro	om page 12		Α.	145				
3. Facility lac		/procedure related to n.						
at approximate was a 61-year 12/29/17 at 19 status, including diabetes mell History & Physpeak English history were used to being non-Endated 1/30/18. Therapy was language asses was okay to be Language The with instruction bedside dyspostaff 7 (Speedat 1906 hours MR lacked do provided in Signated 2/3/18 is commands in that staff provided in Signated 2/3/18 is commands i	ely 1201 hours for old who properly 1201 hours for ong end-stagg tus type 1, a sical indicate. Review of mable to be glish speaking at 1030 hours to be done of stance and e done if oke erapist and if and again of cumentation banish. Physonalicated par Spanish". Mided translational in 2/14/18 at offirmed: ech therapy anguage as allow study	ical records on 2/14/18 urs indicated, patient 1 esented to the facility on r complex medical e renal disease, and encephalopathy. ed patient does not systems and family obtained due to patient ng. Physician Order urs indicated Speech laily with Spanish rehab swallow study ay with Speech Primary Care Physician vided in Spanish. A w study was done by Therapist) on 1/31/18 on 1/3/18 at 1828 hours. In of instructions being sician Progress Note cient "will follow IR lacks documentation cion services to this rently an inpatient at age Therapist) was approximately 1618 was not being done sistance. A bedside was done by this staff of hours and again on						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		152027	B. WING _			C 02/14/2018	
	ROVIDER OR SUPPLIER DSPITAL OF FORT WAY	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	•	02.14.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 145	2/21/18, but there is instructions to be promoted. C. this staff membro documentation statended any educa Spanish for medical 6. Staff 8 (R.N.) was approximately 1705 asked how he/she che/she stated "with gestures". When as language translation speak with the paties staff 8 stated they his services a few hours to use it. 7. Staff 9 (Telemetr Secretary), staff 11 staff 12 (R.N.) were 2/14/18 at approximal nurses station. Whe communicated with and said they didn't Cyracom language is stated they had just few hours ago and continuous with the staff 12 (Chief Clief C	on Spanish. In Sp	A 1	45			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		DATE SURVEY COMPLETED
		152027	B. WING			C 02/14/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805		02/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 145	hours and again on a was no translation se communicate with the is not sure how staff 1. 9. On 2/14/18 at application of the staff and patient Care Unit, accompanied by staff and patient 1 was in and making eye contenglish and had a Neuse OF RESTRAIN CFR(s): 482.13(e) Patient Rights: Restrict patients have the right mental abuse, and compatients have the right mental abuse, and compatients have the right seclusion, of any form coercion, discipline, staff. Restraint or set to ensure the immediate patient, a staff membrated patient, a staff membrated patient of the staff	driving a transfer of the patient. This staff member communicated with Patient aroximately 1700 hours, the oth Floor, was toured from 2 (Chief Clinical Officer) froom 510. He/She was alert fact, but could not speak a tube in place. The other from physical or proporal punishment. All finite to be free from physical or proporal punishment. All for the free from restraint or members, or retaliation by clusion may only be imposed fate physical safety of the finer, or others and must be arliest possible time. The first patient is the proposed for the free from the proposed for the free from the free free from the free from the f	A 14	5		
	information in langua could understand in	o lack of provision of ge and terms the patient order to communicate needs th care decisions for 1 of 10 records reviewed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		152027	B. WING _			C 02/14/2018
	ROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805		5271472010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 154	indicated on pg. 2, pbut is not limited to specialized needs or patient". 2. Policy titled, "Cul revised/reapproved under Procedure se communication apprineeds. See leaders! Communication". 3. Facility lacked a translation communication c	spected Patient ised/reapproved 12/16, soint 5.M., "Neglect includes .Failure to accommodate the f the disabled or elderly tural Competency Diversity", 11/17, indicated on pg. 2, ction, bulleted point, "Modify roaches to meet cultural hip policy on Translation policy/procedure related to ication. Straint Use", 6/16, indicated on pg. 3, point rande to remove the patient on as teness of removal of restraint valuation of the patient's the potential outcome of the medical records on 2/14/18 on hours indicated, patient 1: old who presented to the lat 1954 hours for complex reding end-stage renal	A 1	54		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		152027	B. WING _			C 02/14/2018	
	ROVIDER OR SUPPLIER PSPITAL OF FORT WAYN	E		STREET ADDRESS, CITY, STATE, ZIP CODI 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
A 154	with Speech Language Care Physician with i Spanish. A bedside of done by staff 7 (Speech 1/31/18 at 1906 hours 1828 hours. MR lack instructions being proprogress Note dated follow commands in State of the services to this patient an inpatient at this fact indicated patient was bilateral soft wrist restaily from 12/29/17 at 2/14/18 at 1808 hours tubing/dressing, unabinstructions, sedation disruption of life sustainterviewed on 2/14/1 hours and confirmed: A. Daily speech the with Spanish languaged dysphagia swallow state of the service of 1/31/18 at 1828 hours provided to patient in B. a barium swallow 2/21/18, but there is a instructions to be proceed.	was okay to be done if okay ge Therapist and Primary instructions to be provided in ysphagia swallow study was each Language Therapist) on an again on 1/3/18 at ead documentation of ovided in Spanish. Physician 2/3/18 indicated patient "will Spanish". MR lacks taff provided translation int. This patient is currently cility. In and Flow Records, Medical, in restraints of either traints and/or bilateral mitts at 2000 hours through is to prevent pulling at ele to follow safety (confusion and/or to prevent aining interventions. In anguage Therapist) was at approximately 1618 In any was not being done to assistance. A bedside to ywas done by this staff at 1906 hours and again on and instructions were not Spanish. In study is going to be done no process in place for ovided in Spanish, but has poporting this and has not on courses related to	A 1	54			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		152027	B. WING			C 02/14/2018
NAME OF PROVIDER O				STREET ADDRESS, CITY, STATE, ZIP COI 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805		2/14/2016
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
7. Staff approxii asked h he/she sigesture: languag speak with staff 8 sigesture: languag speak with staff 8 sigesture: languag speak with staff 8 sigesture: languag speak with staff 12 services to use it it. 8. Staff Secreta staff 12 2/14/18 nurses sigesture: languag speak with services staff 12 2/14/18 nurses sigesture: languag speak with staff 12 2/14/18 nurses sigesture: languag speak with services significant staff 12 2/14/18 nurses significant staff 17 4/14 and 170 had a significant significant staff 17 4/14 and 170 had a significant significant staff 17 4/14 and 170 had a significant significant staff 17 4/14 and 170 had a significant significant staff 17 4/14 and 170 had a significant significant staff 17 4/14 and 170 had a significant signifi	mately 1705 had mately 1705 had mately 1705 had maked "with fast". When ask ge translation with the patient stated they had a few hours to a few hours at approximal station. When had approximal station with place of the few had just he had a few hours and they had just he had few hours, and wallow study and again on 1 translation senicate with the few how staff of 2/14/18 at approximal few how staff of 2/14/18 at approxima	interviewed on 2/14/18 at hours, and confirmed when simmunicated with patient 1 acial cues and hand ed to utilize the Cyracom services so surveyor could at who spoke only Spanish, digust learned about the ago and did not know how Technician), staff 10 (Unit Patient Care Technician) and interviewed together on asked how they patient 1, they looked puzzled anow. When asked about the anslation services, they all earned about the services and not know how to use it. and spoken about it in daily 2/7/18, they all stated they the language translation Inical Officer) was interviewed imately 1150, 1239, 1426 confirmed when Patient 1 done on 1/31/18 at 1906 /3/18 at 1828 hours there exists a variable for staff to be patient. This staff member communicated with Patient	A 1	54		

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		152027	B. WING			·	C 14/2018
	ROVIDER OR SUPPLIER SPITAL OF FORT WAYN			STI 220	REET ADDRESS, CITY, STATE, ZIP CODE 00 RANDALLIA DRIVE 5TH FLOOR DRT WAYNE, IN 46805	<u> 021</u>	14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 154		room 510. He/She was alert act, but could not speak	A	154			
A 166	PATIENT RIGHTS: R SECLUSION CFR(s): 482.13(e)(4)	ESTRAINT OR	A	166			
	The use of restraint o (i) in accordance with patient's plan of care.	a written modification to the					
	Based on document the facility failed to er patient's plan of care	not met as evidenced by: review and staff interview, nsure the modification of the with use of restraint for 2 of medical records reviewed.					
	Findings:						
	8., "Documentation is	/16, indicated on pg. 4, point required when restraints ughout the episode of initiate or update the					
	at approximately 120 A. patient 1 Restrain Medical, indicated pa either bilateral soft wirmitts daily from 12/29 2/14/18 at 1808 hours tubing/dressing, unab instructions, sedation disruption of life sustal lacked documentation	nt Order and Flow Records, tient was in restraints of rist restraints and/or bilateral 1/17 at 2000 hours through s to prevent pulling at					

STATEMENT OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		152027	B. WING			1	C 14/2018
	OVIDER OR SUPPLIER	E		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	021	14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 168	Medical, indicated pa wrist restraints daily fi through 2/1/18 at 064 documentation of more on the p.m. shift on 1/3. Staff 2 (Chief Clini on 2/14/18 at approxi and 1700 hours, and and Flow Record doc above-mentioned pat the care plan after reserquired per policy ar PATIENT RIGHTS: R SECLUSION CFR(s): 482.13(e)(5) The use of restraint of accordance with the colicensed independent responsible for the caunder §482.12(c) and or seclusion by hospit State law. This STANDARD is r Based on document the facility failed to en by a physician or othe practitioner prior to the 10 (#1) patient medic Findings:	nt Order and Flow Records, tient was in bilateral soft rom 1/29/18 at 0700 hours 0 hours and lacked diffication of the plan of care /29/18. cal Officer) was interviewed mately 1150, 1239, 1426 confirmed Restraint Order umentation for the ients lacked an update of straints were used as and procedure. ESTRAINT OR r seclusion must be in order of a physician or other practitioner who is are of the patient as specified authorized to order restraint tal policy in accordance with the other procedure. In the series of the patient as specified authorized to order restraint tal policy in accordance with the other practices and staff interview, assure an order was written er licensed independent er use of restraints for 1 of all records reviewed.		166			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		152027	B. WING		02/1) 4/2018	
	ROVIDER OR SUPPLIER SPITAL OF FORT WAYN	E		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805	1 327	1-112010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 168	Continued From page		A 16	68			
		oint 7.b., "Restraint orders d within 24 hours by the ".					
	at approximately 120 Restraint Order and Findicated patient was bilateral soft wrist restaily from 12/29/17 a 2/14/18 at 1808 hour tubing/dressing, unabinstructions, sedation disruption of life sustail	traints and/or bilateral mitts t 2000 hours through s to prevent pulling at ble to follow safety /confusion and/or to prevent aining interventions and signed or dated by the					
A 170	on 2/14/18 at approxi and 1700 hours, and and Flow Record doc above-mentioned pat	ient lacked documentation e and date as required per	A 17	70			
	soon as possible if the order the restraint or This STANDARD is a Based on document the facility failed to er	not met as evidenced by: review and staff interview, nsure the attending physician int use for 1 of 10 (#1)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		152027	B. WING _			1	C / 14/2018	
	ROVIDER OR SUPPLIER SPITAL OF FORT WAYN	E		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805			14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
A 170	Findings: 1. Policy titled, "Rest revised/reapproved 6 bulleted points, "A ph following application or restraints must be in a physician who is respatient and authorize restraints". 2. Review of patient at approximately 120 Restraint Order and Findicated patient was bilateral soft wrist restaily from 12/29/17 at 2/14/18 at 1808 hours tubing/dressing, unabinstructions, sedation disruption of life sustainstruction of life sustainstructions.	raint Use", /16, indicated on pg. 3, ysician must be contacted of the restraintUse of accordance with the order of sponsible for the care of the d by facility to order medical records on 2/14/18 1 hours indicated patient 1 Flow Records, Medical, in restraints of either traints and/or bilateral mitts t 2000 hours through s to prevent pulling at ole to follow safety //confusion and/or to prevent aning interventions and 7/18 and lacked tending physician was se on 1/27/18. cal Officer) was interviewed	A	70				
A 171	and 1700 hours, and and Flow Record doc mentioned patient do attending physician w on 1/27/18 as require PATIENT RIGHTS: R SECLUSION CFR(s): 482.13(e)(8)	mately 1150, 1239, 1426 confirmed Restraint Order umentation for the above cumentation lacked that the ras notified of restraint use d per policy and procedure. ESTRAINT OR	A	71				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		452027	B. WING			1	0
NAME OF D		152027	B. WING	_	27DEET ADDRESS SITV STATE 7/D SODE	02/	14/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE 5TH FLOOR		
VIBRA HO	SPITAL OF FORT WAYN	E			FORT WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 171	` '	raint or seclusion used for	А	171			
	behavior that jeopard safety of the patient, may only be renewed following limits for up (A) 4 hours for adults (B) 2 hours for childred years of age; or (C) 1-hour for childred This STANDARD is a Based on document the facility failed to er restraint and that a new facility failed to the safety of the patients of the	iolent or self-destructive izes the immediate physical a staff member, or others I in accordance with the to a total of 24 hours: 18 years of age or older; en and adolescents 9 to 17 in under 9 years of age; not met as evidenced by: review and staff interview, issure a time limit for use of ew order for restraint was for 2 of 10 (#1 and 2) ds reviewed.					
	1.b)., "A Physician's (/16, indicated on pg. 5, point Order is required every 24					
	2. Review of patient at approximately 120 A. patient 1 Restrai Medical, indicated pa either bilateral soft wimitts daily from 12/29 2/14/18 at 1808 hours tubing/dressing, unabinstructions, sedation disruption of life susta a. the time betwee 24 hours on 1/2/18, 1 The time order starter	nt Order and Flow Records, tient was in restraints of rist restraints and/or bilateral b/17 at 2000 hours through s to prevent pulling at					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		152027	B. WING				C 14/2018	
	ROVIDER OR SUPPLIER SPITAL OF FORT WAYN	IE	•	22	TREET ADDRESS, CITY, STATE, ZIP CODE 200 RANDALLIA DRIVE 5TH FLOOR ORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
A 171	reordered at 1100 ho order started on 1/9/7 reordered at 1400 ho order started on 1/10 reordered at 1700 ho b. restraint order the from 12/29/17 through B. patient 2 Restraint Medical, indicated pawrist restraints daily for through 2/1/18 at 064 time limit is not docur 1/31/18. 3. Staff 2 (Chief Clin on 2/14/18 at approximated 1700 hours, and and Flow Record document of the patient was written aper policy and procest patient was superseded by the use of restraint or management of viole behavior, a physician independent practitio the care of the patient §482.12(c) of this par restraint or seclusion	Is was 0700 hours and urs on 1/8/18. The time Is was 0700 hours and urs on 1/10/18. The time Is was 1400 hours and urs on 1/11/18. The time Is ime limit is not documented in 2/14/18. Into Order and Flow Records, tient was in bilateral soft from 1/29/18 at 0700 hours It in hours and restraint order mented from 1/29/18 through Is in the confirmed Restraint Order cumentation for the cients lacked a time limit for in that a new order for after 24 hours as required dure. ESTRAINT OR The secusion for the into restraint order or seclusion for the into restraint order for after 24 hours as required dure. ESTRAINT OR		171				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		152027	B. WING		02/14/2018	
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	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
A 172	IBRA HOSPITAL OF FORT WAYNE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		A 17	72		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		720.25	A. BOILBING		С		
		152027	B. WING _		02	2/14/2018	
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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
assessindeper order 3. State on 2/1 and 13 and Flabove that a or lice before required sector of the	endent practition for restraint from aff 2 (Chief Clinic 14/18 at approxication of the properties of t	nysician or licensed ner before writing a new n 1/29/18 through 1/31/18. cal Officer) was interviewed mately 1150, 1239, 1426 confirmed Restraint Order umentation for the ients lacked after 24 hours sessment by the physician ent practitioner was done order for restraint as nd procedure. ESTRAINT OR (iii) nentation in the patient's ess restrictive interventions able); not met as evidenced by: review and staff interview, asure alternatives or less as were documented prior to of 10 (#1 and 2) patient ewed.	A 1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		152027	B. WING		C 02/14/2018
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	02/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
A 186	Continued From page	e 26	A 18	36	
A 188	 Review of patient medical records on 2/14/18 at approximately 1201 hours indicated: A. patient 1 Restraint Order and Flow Records, Medical, indicated patient was in restraints of either bilateral soft wrist restraints and/or bilateral mitts daily from 12/29/17 at 2000 hours through 2/14/18 at 1808 hours to prevent pulling at tubing/dressing, unable to follow safety instructions, sedation/confusion and/or to prevent disruption of life sustaining interventions and lacked documentation of patient specific interventions on 1/11/18. B. patient 2 Restraint Order and Flow Records, Medical, indicated patient was in bilateral soft wrist restraints daily from 1/29/18 at 0700 hours through 2/1/18 at 0640 hours and lacked documentation of patient specific interventions on the p.m. shift on 1/29/18. Staff 2 (Chief Clinical Officer) was interviewed on 2/14/18 at approximately 1150, 1239, 1426 and 1700 hours, and confirmed Restraint Order and Flow Record documentation for the above-mentioned patients lacked documentation of patient specific interventions prior to use of restraints as required per policy and procedure. 		A 18	38	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		152027	B. WING		02/14/2018	
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		1 02/14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
A 188	Based on documenthe facility failed to continued use for repatient medical reconstitution are initiated, and through approximately 120. A. patient 1 Restraint use". 2. Review of patient at approximately 120. A. patient 1 Restraint and approximately 120. A. patient 1 Restraint use and the peither bilateral soft with mitts daily from 12/2 2/14/18 at 1808 hou tubing/dressing, unatinstructions, sedation disruption of life sustanced documentation precipitating/continuing the a.m. shift on 12/3 and on the p.m. shift 1/6/18-1/11/18 and 3. patient 2 Restraints daily through 2/1/18 at 06 documentation of the reason for restraints and 1/30/18. 3. Staff 2 (Chief Clirical and continued and 1/30/18.	not met as evidenced by: t review and staff interview, locument rationale for straints for 2 of 10 (#1 and 2) rds reviewed. straint Use", 6/16, indicated on pg. 4, point is required when restraints oughout the episode of t medical records on 2/14/18 01 hours indicated: aint Order and Flow Records, atient was in restraints of wrist restraints and/or bilateral 9/17 at 2000 hours through rs to prevent pulling at able to follow safety n/confusion and/or to prevent taining interventions and on of the ed reason for restraints on 30/17, 1/8/18 and 1/10/18; t on 12/29/17-1/3/18, 1/27/18. aint Order and Flow Records, atient was in bilateral soft from 1/29/18 at 0700 hours	A 188			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		152027	B. WING			C / 14/2018	
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	1 32	71-72010	
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 188	and Flow Record doc above-mentioned par	confirmed Restraint Order cumentation for the tients lacked documentation ontinued reason for restraints y and procedure.	A 18				
7.450	CFR(s): 482.24(c)(1) All patient medical re complete, dated, time written or electronic f responsible for provided, consistent procedures. This STANDARD is Based on document the facility failed to elentries including date	cord entries must be legible, ed, and authenticated in					
	Findings: 1. Policy titled, "Med Requirements", revisindicated on pg. 2, pomedical record must and timed". 2. Review of patient at approximately 120 A. patient 1 Restrait Medical, indicated paeither bilateral soft with mitts daily from 12/28 2/14/18 at 1808 hour tubing/dressing, unab	ical Record Documentation ed/reapproved 12/16, pint 7., "All entries into the be legible, signed, dated, medical records on 2/14/18 1 hours indicated: nt Order and Flow Records, attent was in restraints of rist restraints and/or bilateral 20/17 at 2000 hours through s to prevent pulling at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		152027	B. WING_			C	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		2/14/2018	
VIBRA HOSPITAL OF FORT WAYNE				2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 450	disruption of life susta 1. restraint order ti legible on 1/5/18 and physician or Register 2. lacked documer a.m. shift on 12/30/17-1/5/ 1/27/18. 2. Staff 2 (Chief Clini on 2/14/18 at approxi and 1700 hours, and above-mentioned pat	aining interventions and: ime is blank on 1/4/18, not not signed or dated by the ed Nurse (R.N.) on 1/27/18. Intation of R.N. initials on the r and 1/5/18; on the p.m. 18, 1/8/18-1/11/18 and cal Officer) was interviewed mately 1150, 1239, 1426 confirmed for the ients MR documentation mplete entries including	A 4	450			