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	03/14/2018

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	This visit was for a follow up survey of one Federal hospital Immediate Jeopardy (IJ) complaint survey conducted on 2/14/18. The Immediate Jeopardy was removed. Complaint Number: IN00254140 Date: 3/14/18 Facility Number: 012132 QA: 3/22/18	A 0000	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.	
A 0115 Bldg. 00	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. Based on document review and interview the facility failed to ensure restraints were discontinued at the earliest time possible for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. (see tag 154), failed to ensure the modification of the patient's plan of care with use of restraint for 1 of 2 (#3) patient medical records reviewed of patients in restraint. (see tag 166), failed to document the appropriate type and/or placement of restraint implemented according to facility policy and procedure for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. (see tag 167), failed to ensure an order was written by a physician or other licensed independent practitioner prior to the use of restraints for 1 of 2 (#3) patient medical records reviewed of patients in restraints. (see tag 168), failed to ensure the attending physician was notified of restraint use for 2 of 2 (#2 and 3) patient medical records reviewed of patients in	A 0115	New attending group started on 3/8/18 and implemented daily rounding with clinical team members. During rounding, patient assessments are completed and an assessment of the need to continue or discontinue restraints is reviewed. Justification of restraint need is reviewed and documented daily on Restraint Flow Sheet. **Prevent Reoccurrence:** Immediate Process change: Shift huddles conducted to review Restraint Policy and Flow sheet documentation. Day shift nursewill implement Restraint FlowSheet during daily clinical rounding. New order obtainedand placed on nursing work list to notify nurse of every 2hour	03/15/2018

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

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	restraints. (see tag 170), failed to ensure physician orders included the duration and/or a time limit for use of restraint for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. (see tag 171), failed to ensure after 24 hours that a face-to-face assessment by the physician or licensed independent practitioner (LIP) was done before writing a new order for restraint for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. (see tag 172), failed to ensure the condition of the patient who is restrained is monitored according to intervals determined by hospital policy for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. (see tag 175), and failed to document rationale for continued use for restraints for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. (see tag 188) The cumulative effect of these systemic problems resulted in the hospital's inability to ensure that Patients Rights were promoted.		rounding requirement. A post restraint assessment will be conducted during daily clinical rounding following all initialrestraint orders. This review will include the type and placement of restraints. **Person Responsible:** Chief Clinical Officer **Monitoring:** **# of completed restraint flowsheet / # of patients with restraints** **Goal:** **100% completion of restraint flowsheet for 3 consecutive months. Outcomes reported to QAPI,MEC &GB.**	
A 0154 Bldg. 00	482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. Based on document review and interview the facility failed to ensure restraints were discontinued at the earliest time possible for 2 of	A 0154	1. Daily clinical rounding is completed to review the need to continue or	03/15/2018

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	2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 3, point 3., "Every attempt is made to remove the patient from restraint as soon as possible...If the physician elects to discontinue the restraint order prior to its expiration, a discontinue order must be written." 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated, patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 indicated patient was in soft limb restraints x2 and physician order was timed at 0800 hours. There was no documentation of checks by nurse every 2 hours, so it cannot be determined how long the patient was in restraints. The flowsheet lacked documentation of discontinuation order of restraints. B. #3, Restraint Order and Flow Record, Medical, dated: a. 2/21/18 indicated patient was in soft limb restraint x1 from 0700 hours to 0659 hours. The flowsheet lacked documentation of discontinuation order of restraint. b. 2/22/18 indicated patient was in soft limb restraints x2 from 2200 hours to 0659 hours. The flowsheet lacked documentation of discontinuation order of restraint for time period of 0700 hours to 2100 hours when patient was not in restraints. c. 3/1/18 indicated patient was in soft limb restraint x1 from 0700 hours to 0450 hours. The flowsheet lacked documentation of discontinuation order of restraint for time period of 2100 hours to 0244 hours when patient was not in restraints.		discontinue restraint use. If restraints are discontinued, an order is written during rounding. 2. A. Daily review of documentation to be completed prior to the end of shift by staff nurse and nurse supervisor. B. a. through f. Physician daily rounding discusses discontinuation of restraints. Order is documented in the EMR and on the Restraint flow sheet. 3. Education to staff on restraint discontinuation reviewed with staff educator. **Prevent Reoccurrence:** Shift supervisor will review all flow sheets for currently restrained patients of required documentation. This assessment will determined to continue or discontinue restraint use. New order to continue or discontinue will be completed during daily clinical rounding with physician. **Responsible Party:** Chief Clinical Officer **Monitoring:** **# of completed restraint 2 hour documentation per shift / # of restraint patients with review of 100% patients in restraints** **Goal:** **100% Compliance for the 3 consecutive months.**	

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	d. 3/6/18 indicated patient was in soft limb restraint x1 from 0700 hours to 1800 hours. The flowsheet lacked documentation of discontinuation order of restraint for time period of 1900 hours to 0659 hours when patient was not in restraints. e. 3/10/18 indicated patient was in soft limb restraints x2 from 1920 hours to 0538 hours. The flowsheet lacked documentation of discontinuation order of restraint for time period of 0700 hours to 1919 hours when patient was not in restraints. f. 3/12/18 indicated patient was in soft limb restraint x1 from 0700 hours to 1300 hours. The flowsheet lacked documentation of discontinuation order of restraint for time period of 1301 hours to 0659 hours. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation of a discontinuation order of restraint as required per policy and procedure.			
A 0166 Bldg. 00	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. Based on document review and interview, the facility failed to ensure the modification of the patient's plan of care with use of restraint for 1 of 2 (#3) patient medical records reviewed of patients in restraint. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 3, point	A 0166	1. - 3. Reviewed Restraint Care Plan documentation with clinical staff beginning on 2/15/2018 and refresher review March 15, 2018 - April 6, 2018. **Prevent Reoccurrence:** **Staff nurse to review patient care plans regarding restraints dailyand update care plan**	03/15/2018

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	8., "Documentation is required when restraints are initiated, and throughout the episode of restraint use and will initiate or update the Nursing Care Plan: Risk for Injury". 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated on patient #3's, Restraint Order and Flow Record, Medical, dated 3/5/18 that patient was in soft limb restraint x1 from 0800 hours to 0500 hours. The flowsheet lacked documentation of modification of the plan of care on the a.m. shift. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation of an update of the care plan after restraints were used as required per policy and procedure.		**accordingly.** **Responsible Party:** **Chief Clinical Officer** **Monitoring:** **# of Patients with correct care plan regarding restraints / # of patients in restraints** **Goal: 100% completion of restraint care plan documented in HMS for 3 month. Audit results will be reported to QAPI, MEC and Governing Board committees.**	
A 0167 Bldg. 00	482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. Based on document review and interview, the facility failed to document the appropriate type and/or placement of restraint implemented according to facility policy and procedure for 2 of 2 (#2 and 3) patient medical records reviewed of	A 0167	1. - 3. Reviewed Restraint Care Plan documentation with clinical staff beginning on 2/15/2018 and refresher review March 15, 2018 - April 6, 2018. Type of restraint documented on Restraint Flow	03/15/2018

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	patients in restraints. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 3, under General Provisions, bulleted point, "A Physician's Order is required to initiate, change, continue, and discontinue restraint. The order must include the type and number of restraints..." 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 indicated that patient was in soft limb restraints x2, but lacked documentation of where the restraints were placed. B. #3, Restraint Order and Flow Record, Medical, dated: a. 2/21/18 indicated that patient was in soft limb restraint x1, but lacked documentation of where the restraint was placed. b. 3/12/18 lacked a checkmark in the box indicating type of restraint, but a number 1 was placed after soft limb restraint. Documentation under Placement section indicated right and left arm, which contradicts the number 1 placed after soft limb restraint. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation of either the type and/or placement of restraint as required per policy and procedure.		Sheet. **Prevent:** Process change: Day shift nurse will implement new 24 hour restraint flow sheet during Physician and clinical rounding daily. New order obtained and placed on nursing work list for 2 hour rounding requirement. Nursingshift supervisor to review allrestraint patient orders for completeness to include type and placement of restraint. **Responsible Person:** **Chief Clinical Officer** **Monitoring:** **# of patients with completed documentation to include type of restraint and placement / # of patients in restraints.** **Goal:** 100% of patient restraint documentation completed per shift and reviewed for 3 month.Audit data will be reported to QAPI, MEC and Governing Board.	
A 0168 Bldg. 00	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in			

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	accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. Based on document review and interview, the facility failed to ensure an order was written by a physician or other licensed independent practitioner prior to the use of restraints for 1 of 2 (#3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 3, under General Provisions section, bulleted point, "A physician's order is required to initiate, change, continue, and discontinue restraint." 2. Policy titled, "Medical Record Documentation Requirements", revised/reapproved 12/16, indicated on pg. 2, point 7.b., "Restraint orders must be authenticated within 24 hours by the prescribing physician". 3. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated on patient #3's, Restraint Order and Flow Record, Medical, dated: A. 3/2/18 that patient was in soft limb restraint x1 from 0700 hours to 0650 hours. Physician's order is timed at 0930 hours, which is after 0700 hours on 3/2/18 and was not indicated to be a telephone or verbal order. The flowsheet lacked a physician order for restraint from 0700 hours to 0929 hours. B. 3/5/18 that patient was in soft limb restraint x1 from 0800 hours to 0500 hours. Physician's order is timed at 1400 hours, which is after 0800	A 0168	1. Daily Physician rounding started on 3/8/2018. Daily assessments are performed and restraints are reviewed during this time. Restraint changes will be written during daily rounds. 2. Physician orders are authenticated daily during clinical rounding. 3. A. - D., 4. Restraints are discussed daily during clinical rounding. Orders completed during rounding and Restraint Flow Sheet initiated. **Prevent Reoccurrence:** Ensure physician order is authenticated every day to continue or discontinue restraint use. This is reviewed during daily clinical rounding every morning with the attending physician. **Person Responsible:** Chief Clinical Officer **Monitoring:** **# of completed restraint orders documented on Restraint flow sheet / # of patients in restraints** **Goal:** 100% completion of physician orders daily reviewed for 3 month. Audit results will be reported to QAPI, MEC and Governing Board committees.	03/15/2018

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	hours on 3/5/18 and was not indicated to be a telephone or verbal order. The flowsheet lacked a physician order for restraint from 0800 hours to 1359 hours. C. 3/6/18 that patient was in soft limb restraint x1 from 0700 hours to 1800 hours. Physician's order is timed at 1000 hours, which is after 0700 hours on 3/6/18 and was not indicated to be a telephone or verbal order. The flowsheet lacked a physician order for restraint from 0700 hours to 0959 hours. D. 3/12/18 that patient was in soft limb restraint x1 from 0700 hours to 1300 hours. Physician's order lacked a time. The flowsheet lacked a physician order for restraint from 0700 hours to 1300 hours. 4. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation of a physician order for restraint as required per policy and procedure.			
A 0170 Bldg. 00	482.13(e)(7) PATIENT RIGHTS: RESTRAINT OR SECLUSION The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion. Based on document review and interview, the facility failed to ensure the attending physician was notified of restraint use for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on Attachment	A 0170	1. Clinical team will notify Admitting Physician for initial restraint order prior to application or following emergency application of restraints. 2. A. - B., 3. Clinical team re-educated on the need to contact physician for an order when discontinuing or changing restraints status.	03/15/2018

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	A, under Medical Restraint; Initial Order section, bulleted point, "Physician/LIP (Licensed Independent Practitioner) must be contacted prior to application or immediately following emergency application of restraints". 2. Review of patient medical records (MRs) on 3/14/18 at approximately 1317 hours indicated patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 indicated that patient was in soft limb restraints x2, but unable to determine time applied to time discontinued because nurse assessment every 2 hours was lacking. Reasons for restraint included, to prevent pulling at tubing/dressing and/or unable to follow safety instructions. MR lacked documentation the attending physician was notified of restraint use. B. #3, Restraint Order and Flow Record, Medical, dated: a. 3/5/18 indicated that patient was in soft limb restraint x1 from 0800 hours to 0500 hours. MR lacked documentation the attending physician was notified of restraint use. b. 3/6/18 that patient was in soft limb restraint x1 from 0700 hours to 1800 hours. MR lacked documentation the attending physician was notified of restraint use. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked that the attending physician and/or LIP was notified of restraint use as required per policy and procedure.		**Prevent Reoccurrence:** **Current physician coverage is provided by a group of physicians. The attending physician will benotified of an initial order. Anymember of the attending group canorder and confirm the need to continue or discontinue the need for restraints. Availability of physician coverage is 24 hours.** **Responsible:** **Chief Clinical Officer** **Monitoring:** **# of patients placed in restraints where attending was notified/ # of initial restraint order** **Goal:** **100% completion of notification to attending physician of initial order.**	
A 0171 Bldg. 00	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive--			

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	(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; Based on document review and interview, the facility failed to ensure physician orders included the duration and/or a time limit for use of restraint for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 3, under General Provisions, bulleted point, "A Physician's Order is required to initiate, change, continue, and discontinue restraint. The order must include the type and number of restraints and duration." 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 indicated that patient was in soft limb restraints, but lacked documentation of duration and/or time limit of restraint use. B. #3, Restraint Order and Flow Record, Medical, dated 2/21/18, 2/22/18, 3/1-3/6/18, and 3/10-3/12/18 indicated that patient was in soft limb restraints, but lacked documentation of duration and/or time limit of restraint use. 3. Staff 8 (Nurse Manager) was interviewed on	A 0171	1. A.-B., 3. Physician rounding began on 3/8/2018. Restraints are reviewed during rounding and orders updated according to patient assessment. **Prevent Reoccurrence:** The patient is assessed by a physician daily to determine continuation of restraint use. This order to continue or discontinue restraint use is documented on restraint flow sheet. If the staff nurse sees a change in status of the patient at any time, the physician will be notified and a new order will be documented and a new restraint flow sheet will be started. Additionally the clinical team will determine during morning clinical rounding after assessment if the need to continue or discontinue restraint use. Type and number of restraints will be updated. **Responsible Party:** Chief Clinical Officer **Monitoring:** # of patients with daily order in place / # of patients with restraints	03/15/2018

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	3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation that the physician order included duration and/or time limit of restraint use as required per policy and procedure.		**Goal:** 100% completion of daily restraint order from physician documented, audited for3 months and reviewed at monthly QAPI, MEC and Governing Board.	
A 0172 Bldg. 00	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION [Unless superseded by State law that is more restrictive,] (ii) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient. Based on document review and interview, the facility failed to ensure after 24 hours that a face-to-face assessment by the physician or licensed independent practitioner (LIP) was done before writing a new order for restraint for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 4, point 1.b)., "A face-to-face assessment of the patient by the attending physician is documented daily following initiation of restraint and before renewal of restraint orders". 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated patient:	A 0172	Daily clinical rounding is conducted with physician to review and assess patient and update restraint need. A new order will be written to continue or discontinue restraint use. **Prevent:** The clinical team, including the physician rounds on all patients daily to complete assessment and if there is a need to continue or discontinue use of patient restraint. New order to continue or discontinue will be completed by the physician after a face to face assessment. **Responsible Person:** **Chief Clinical Officer**	03/15/2018

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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. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 indicated that patient was in soft limb restraints, but lacked documentation after 24 hours of a face-to-face assessment by the physician or LIP before writing a new order for restraint. B. #3, Restraint Order and Flow Record, Medical, dated 2/21/18, 2/22/18, 3/1-3/6/18, and 3/10-3/12/18 indicated that patient was in soft limb restraints, but lacked documentation after 24 hours of a face-to-face assessment by the physician or LIP before writing a new order for restraint. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation of a face-to-face assessment by the physician or LIP before writing a new order for restraint as required per policy and procedure.		**Monitoring:** **# of patients with daily order in place /# of patients with face to face assessment** **Goal:** **100% Completion of daily restraint order by physician will be reviewed for 3 month and reported to QAPI, MEC and Governing Board committees.**	
A 0175 Bldg. 00	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. Based on document review and interview, the facility failed to ensure the condition of the patient who is restrained is monitored according to intervals determined by hospital policy for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings:	A 0175	1., 2 A.-B., 3. Restraint Policy reviewed with clinical staff.**Documentation/assessment to be providedevery 2 hours while patient is in restraints** **Prevent Reoccurrence:** Process change will have Day Shift nurse implement restraint flow sheet during clinical	03/15/2018

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	1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 4, point 2.c)., "On-going assessment includes: Minimally every 2 hours or more frequently if condition warrants, the patient's safety and other needs are assessed and documented on the Restraint Order and Flow Record, Medical...". 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 indicated that patient was in soft limb restraints x2 and unable to determine time started or ended, but physician time of order was 0800 hours. The flowsheet lacked documentation of Registered Nurse (R.N.) initials and time every 2 hours that the "required assessment was completed and care provided per [facility] policy." B. #3, Restraint Order and Flow Record, Medical, dated 3/12/18 indicated that patient was in soft limb restraint x1 and unable to determine time started or ended because physician order time is blank. The flowsheet lacked documentation of R.N. initials and time every 2 hours that the "required assessment was completed and care provided per [facility] policy." 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation of R.N. initials and time indicating patients in restraints were monitored minimally every 2 hours as required per policy and procedure.		rounding. New order obtained and placed on nursing work list for 2 hour rounding requirement. **Responsible Party:** **Chief Clinical Officer** **Monitoring:** **# of completed restraint flow sheets / # of patients in restraints** **Goal:** **100% Completion of restraint flow sheet for 3 consecutive months. Data findings will be reported to QAPI, MEC and Governing Board.**	
A 0188 Bldg. 00	482.13(e)(16)(v) PATIENT RIGHTS: RESTRAINT OR SECLUSION			

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	[there must be documentation in the patient's medical record of the following:] The patient's response to the intervention(s) used, including the rationale for continued use of the intervention. Based on document review and interview, the facility failed to document rationale for continued use for restraints for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on Attachment A, under Medical Restraint; Nursing Assessment and Documentation Required section, bulleted point, "Includes assessment of continued need...". 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 indicated that patient was in soft limb restraints, but lacked documentation of continued reason for restraint on the a.m. and p.m. shifts. B. #3, Restraint Order and Flow Record, Medical, dated 3/1/18 (p.m. shift), 3/4/18 (p.m. shift) and 3/11/18 (p.m. shift) indicated that patient was in soft limb restraints, but lacked documentation of continued reason for restraint. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation of continued reason for restraint as required per policy and procedure.	A 0188	1. A., 2. A-B, 3. Clinical team will document on Restraint Flow Sheet the reason to continue use of restraints. **Prevent:** **The patient is assessed by the nurse every shift to determine continuation of restraint use basedon patient safety. This sdocumented on restraint flowsheet. In addition the clinical teamincluding the physician round onthe patient daily to assess forcontinued restraint use.** **Responsible party:** **Chief Clinical Officer** **Monitoring:** **# of patients with justification for continued restraint in place / # of patients with restraints** **Goal:** **100% assessment review of continued patient need for restraints on daily Restraint Flowsheet for 3 month. Data findings will be reported to QAPI, MEC and Governing Board.**	03/15/2018

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A 0273 Bldg. 00	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. Based on document review and interview, the facility failed to ensure the Quality Assessment and Performance Improvement Program (QAPI) collected, analyzed, and/or tracked information related to restraint use to monitor the effectiveness and safety of services and quality of	A 0273	In review of the MEC minutes provided to the surveyor it was discovered that the reviewed document was for an Ad Hoc meeting. This special Ad Hoc meeting was on 2/15/2018. This	03/15/2018

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	patient care; and failed to report this information by the QAPI Committee to the Medical Executive Committee (MEC) and the Governing Board (GB). Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 1, under Policy section, bulleted point, "Data on restraint use will be collected and reported to Quality Assessment/Performance Improvement and on throughout the committee reporting structure." 2. Review of Ad Hoc MEC Meeting Minutes and Ad Hoc GB Meeting Minutes on 3/14/18 at approximately 1317 hours that were dated 2/15/18, lacked documentation that the QAPI Program collected, analyzed, tracked and/or reported information related to restraint use to monitor the effectiveness and safety of services and quality of patient care. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the QAPI Program was not collecting, analyzing, and/or tracking all pertinent information related to restraint use and was not reporting information to the MEC or GB as required per facility policy and procedure. This staff member is responsible for The Monthly Restraint Audit Tool (MRAT) that was started in February of 2018 and this tool was not capturing all of the deficiencies in documentation related to use of restraint. Information not being collected, analyzed, tracked and/or reported included, but was not limited to: type and/or placement of restraint, notification of attending physician of restraint use and time, time of physician order, time of Registered Nurse (R.N.) signature after		was called to review the additional polices added to the Fort Wayne library. This Ad Hoc meeting only discussed policies. The monthly MEC regular meeting on 2/26/2018 reviewed and discussed the Restraint Review documentation. As discussed during audit, Restraints are discussed during MEC monthly meetings. Nursing Leadership educated on 3/28/2018 that auditing and review processes occur during QAPI, MEC and Governing Board.	

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	physician order, discontinuation of restraint, R.N. initials and time for monitoring patient at least every 2 hours, precipitating/continued reason for restraint, patient specific interventions, R.N. initials for the a.m. and p.m. shifts, modification of plan of care, and/or initials and signature of R.N. at the bottom of the flowsheet. This staff member indicated the MRAT was incomplete and confusing.			
A 0450 Bldg. 00	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Based on document review and interview, the facility failed to ensure legible and complete entries including but not limited to date, time, and authentication for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Medical Record Documentation Requirements", revised/reapproved 12/16, indicated on pg. 2, points 7.a. and b., "All entries into the medical record must be legible, signed, dated, and timed...Restraint orders must be authenticated within 24 hours by the prescribing physician." 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 lacked documentation of and/or was blank for: a. where the restraint was placed; b. notification of attending physician of	A 0450	Nursing to contact admitting physician for restraint order and initial Restraint low Sheet if physician is not on site. Authentication will occur during physician rounding daily. **Prevent:** **Process change: Day shift nurse will implement new 24 hour restraint flow sheet during Physician and clinical rounding daily. New order obtained and placed on nursing work list for 2 hour rounding requirement. Nursing shift supervisor to review all restraint patient orders and patient restraint flow sheet for completeness to include type and placement of restraint. Shift supervisor will review documentation of physician notification in the medical**	03/15/2018

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	restraint use with time; c. discontinuation of restraint; d. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours; e. precipitating/continued reason for restraint; g. patient specific interventions; h. R.N. initials for the a.m. and p.m. shifts; i. modification of plan of care; j. initials and signature of R.N. at the bottom of the flowsheet. B. #3, Restraint Order and Flow Record, Medical, dated 2/21/18, 2/22/18, 3/1/18, 3/2/18, 3/4-3/6/18, and 3/10-3/12/18 lacked documentation of and/or was blank for: a. where the restraint was placed; b. notification of attending physician of restraint use with time; c. time of physician order; d. time of R.N. signature after physician order; e. discontinuation of restraint; f. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours; g. precipitating/continued reason for restraint; h. patient specific interventions; i. R.N. initials for the a.m. and p.m. shifts; j. modification of plan of care; k. initials and signature of R.N. at the bottom of the flowsheet. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation and/or had blanks as described and facility policy and procedure was not being followed.		**record.** **Responsible Person:** **Chief Clinical Officer** **Monitoring:** **# of completed restraint documentation/ # of patients in restraints.** **Goal:** **100 % of patient documentation complete per shift regarding restraint documentation reviewed for 3 month. Findings will be sent to QAPI, MEC and Governing Board.**	
S 0000 Bldg. 00				

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	This visit was for a follow up investigation of a state licensure hospital complaint survey conducted on 2/14/18. Complaint Number: IN00254140 Date: 3/14/18 Facility Number: 012132 QA: 3/22/18	S 0000		
S 0408 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (2) All functions, including but not limited to the following: (A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i). Based on document review and interview, the facility failed to ensure there was an effective, organized, hospital-wide Quality Assessment and Performance Improvement Program (QAPI) that collected, analyzed, and/or tracked information related to restraint use to monitor the	S 0408	In review of the MEC minutes provided to the surveyor it was discovered that the reviewed document was for an Ad Hoc meeting. This special Ad Hoc meeting was on 2/15/2018. This	03/15/2018

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	effectiveness and safety of services and quality of patient care; and failed to report this information by the QAPI Committee to the Medical Executive Committee (MEC) and the Governing Board (GB). Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on pg. 1, under Policy section, bulleted point, "Data on restraint use will be collected and reported to Quality Assessment/Performance Improvement and on throughout the committee reporting structure." 2. Review of Ad Hoc MEC Meeting Minutes and Ad Hoc GB Meeting Minutes on 3/14/18 at approximately 1317 hours that were dated 2/15/18, lacked documentation that the QAPI Program collected, analyzed, tracked and/or reported information related to restraint use to monitor the effectiveness and safety of services and quality of patient care. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the QAPI Program was not collecting, analyzing, and/or tracking all pertinent information related to restraint use and was not reporting information to the MEC or GB as required per facility policy and procedure. This staff member is responsible for The Monthly Restraint Audit Tool (MRAT) that was started in February of 2018 and this tool was not capturing all of the deficiencies in documentation related to use of restraint. Information not being collected, analyzed, tracked and/or reported included, but was not limited to: type and/or placement of restraint, notification of attending physician of restraint use and time, time of physician order,		was called to review the additional polices added to the Fort Wayne library. This Ad Hoc meeting only discussed policies. The monthly MEC regular meeting on 2/26/2018 reviewed and discussed the Restraint Review documentation. As discussed during audit, Restraints are discussed during MEC monthly meetings. Nursing Leadership educated on 3/28/2018 that auditing and review processes occur during QAPI, MEC and Governing Board **Prevent Reoccurrence:** **Restraint flow policy reviewed with clinical staff on 3/15/2018. Specifically reviewing expectations of restraint flow sheet documentation completeness. Data collected from restraint audits is reported through QAPI, Mec and Governing Board.** **Responsible Party:** **Chief Clinical Officer** **Monitoring:** **# of clinical audits conducted/ # of clinical audits reviewed through committees.** **Goal:** **100% review of clinical audits through QAPI and committees.**	

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	time of Registered Nurse (R.N.) signature after physician order, discontinuation of restraint, R.N. initials and time for monitoring patient at least every 2 hours, precipitating/continued reason for restraint, patient specific interventions, R.N. initials for the a.m. and p.m. shifts, modification of plan of care, and/or initials and signature of R.N. at the bottom of the flowsheet. This staff member indicated the MRAT was incomplete and confusing.			
S 0744 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on document review and interview, the facility failed to ensure legible and complete entries including but not limited to date, time, and authentication for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Medical Record Documentation Requirements", revised/reapproved 12/16, indicated on pg. 2, points 7.a. and b., "All entries into the medical record must be legible, signed, dated, and timed...Restraint orders must be authenticated within 24 hours by the prescribing physician." 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 lacked documentation of and/or was blank for: a. where the restraint was placed;	S 0744	1. Nursing to contact admitting physician for restraint order and initial Restraint Flow Sheet if physician is not on site. Authentication will occur during physician rounding daily. 2. A - B., 3. Nursing education provided to clinical staff to ensure completion of restraint flow sheet prior to end of shift. **Prevent Reoccurrence:** **Restraint flow policy reviewed with clinical staff on 3/15/2018. Specifically reviewing expectations of restraint flow sheet documentation completeness. Data collected from restraint audits is reported through QAPI, Mec and Governing Board.** **Responsible Party:** **Chief Clinical Officer**	03/15/2018

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	b. notification of attending physician of restraint use with time; c. discontinuation of restraint; d. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours; e. precipitating/continued reason for restraint; g. patient specific interventions; h. R.N. initials for the a.m. and p.m. shifts; i. modification of plan of care; j. initials and signature of R.N. at the bottom of the flowsheet. B. #3, Restraint Order and Flow Record, Medical, dated 2/21/18, 2/22/18, 3/1/18, 3/2/18, 3/4-3/6/18, and 3/10-3/12/18 lacked documentation of and/or was blank for: a. where the restraint was placed; b. notification of attending physician of restraint use with time; c. time of physician order; d. time of R.N. signature after physician order; e. discontinuation of restraint; f. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours; g. precipitating/continued reason for restraint; h. patient specific interventions; i. R.N. initials for the a.m. and p.m. shifts; j. modification of plan of care; k. initials and signature of R.N. at the bottom of the flowsheet. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation and/or had blanks as described and facility policy and procedure was not being followed.		**Monitoring:** **# of clinical audits conducted/ # of clinical audits reviewed through committees.** **Goal:** **100% review of clinical audits through QAPI and committees.**	
S 0930	410 IAC 15-1.5-6 NURSING SERVICE			

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VIBRA HOSPITAL OF FORT WAYNE	2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805

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Bldg. 00	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, nursing services failed to supervise and evaluate the care planned related to use of restraint including: type and/or placement of restraint, modification of plan of care, notification of attending physician of restraint use, monitoring patient at least every 2 hours, and/or rationale for continued use of restraint for 2 of 2 (#2 and 3) patient medical records reviewed of patients in restraints. Findings: 1. Policy titled, "Restraint Use", revised/reapproved 2/18, indicated on: A. pg. 3, under General Provisions, bulleted point and point 8., "A Physician's Order is required to initiate, change, continue, and discontinue restraint. The order must include the type and number of restraints...Documentation is required when restraints are initiated, and throughout the episode of restraint use and will initiate or update the Nursing Care Plan: Risk for Injury". B. Attachment A, under Medical Restraint; Initial Order section; and Nursing Assessment and Documentation Required section, bulleted points, "Physician/LIP (Licensed Independent Practitioner) must be contacted prior to application or immediately following emergency application of restraints...Includes assessment of continued need...". C. pg. 4, point 2.c)., "On-going assessment includes: Minimally every 2 hours or more	S 0930	1. A.-C. Daily clinical rounding is conducted with physician to review and assess patient and update restraint need. A new order will be written to continue or discontinue restraint use and the attending physician will be notified. 2. - 3. Nursing re-educated on need for documentation completeness. **Prevent Reoccurrence:** The clinical team, including the physician rounds on all patients daily to complete assessment and if there is a need to continue or discontinue use of patient restraint. New order to continue or discontinue will be completed by the physician. In emergent situations physician will be contacted after placement and documented on restraint flow sheet. **Responsible Person:** **Chief Clinical Officer** **Monitoring:** **# of patients with complete daily order and documentation in place /# of patients with restraints**	03/15/2018

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	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	frequently if condition warrants, the patient's safety and other needs are assessed and documented on the Restraint Order and Flow Record, Medical...". 2. Review of patient medical records on 3/14/18 at approximately 1317 hours indicated patient: A. #2, Restraint Order and Flow Record, Medical, dated 2/16/18 lacked documentation of and/or was blank for: a. where the restraint was placed; b. notification of attending physician of restraint use with time; c. Registered Nurse (R.N.) initials and time for monitoring patient at least every 2 hours; d. continued reason for restraint; e. modification of plan of care. B. #3, Restraint Order and Flow Record, Medical, dated 2/21/18, 2/22/18, 3/1/18, 3/2/18, 3/4-3/6/18, and 3/10-3/12/18 lacked documentation of and/or was blank for: a. type (3/12/18) and/or where the restraint was placed; b. notification of attending physician of restraint use with time; c. R.N. initials and time for monitoring patient at least every 2 hours; d. continued reason for restraint; e. modification of plan of care. 3. Staff 8 (Nurse Manager) was interviewed on 3/14/18 at approximately 1339 hours, and confirmed the above-mentioned Restraint Order and Flow Records, Medical, lacked documentation and/or had blanks as described and nursing staff were not following facility policy and procedure.		**Goal:** 100% Completion of daily restraint order by physician will be reviewed for 3 month and reported to QAPI, MEC and Governing Board committees.	