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	11/29/2016

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
S 0000 Bldg. 00	The visit was for a State licensure survey. Facility Number: 012132 Survey Date: 11/28-29/16 QA: 12/29/2016 LH	S 0000		
S 0308 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on document review and interview, the governing board failed to ensure the job specific orientation for 1 of 3 agency nurses, staff member N6. Findings Include: 1. Review of the personnel file for agency RN (registered nurse) N6	S 0308	The following process will be adhered to 100% in regards to any newly hired nurse (both agency and staff): 1. All newly hired nurses will attend job specific orientation prior to their first day working with patients. 2. All required nursing competencies will be completed during the orientation period, prior	01/27/2017

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

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	indicated: A. They first worked at the facility 10/7/16. B. A section of the document "Core Competency/Demonstration Hospira Plum IV (intravenous) Pump" was blank. C. A section of the "Core Competency/Demonstration Clinical Alarms" page was blank. D. The whole page for "Competency/Demonstration Restraints" was blank. E. All three pages of the document for verifying that the "orientee understands or is competent to perform the items listed on this form" were blank and included: "Sign In:...Assessments:...Order Entry:...Care Plans:...Medication Reconciliation:...E-MAR worklist:...Administered Meds:...Discharge Process:...Misc:..." with no employee or evaluator's signatures and dates. 2. Review of agency RN files N6, N7 and N8 and contracted dialysis nurses N9 and N10 files indicated none had documentation of orientation/competency for performing blood transfusions. 3. At 1:30 PM on 11/29/16, interview with the scheduler and person responsible for agency/dialysis nursing files, staff		to the nurse being assigned a patient, without a preceptor. 3. All dialysis nurses will be required to complete the nursing competency for Blood Administration/ transfusions. Staff Educator will be contacting Fresenius (our contracted dialysis service) to provide them with a mandatory Blood Transfusion Education Packet, post test and Nursing Competency for Blood Administration. All nurses sent to Vibra to provide dialysis support must have this completed paperwork in their files, prior to providing service to our patients. The Staff Educator will also meet these nurses 1 on 1 to expedite getting this completed as soon as possible. MONITOR: Audit all new agency nurse files upon hire to ensure packet is complete and do a general audit monthly RESPONSIBLE PARTY: Staffing Coordinator	

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	member #55, confirmed that: Agency RN N6 was no longer in orientation but lacked completion of the orientation documents as listed in 2. above.			
S 0320 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(G) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee. Based on document review and interview, the governing board failed to ensure that a post offer physical examination was completed for 1 of 1 LPN (licensed practical nurse) file reviewed, staff member N2. Findings Include: 1. Review of the policy "Employee Health Services", reference/policy	S 0320	All newly hired staff will be sent for their pre-hire physical exam, including the required blood-work for Hepatitis B, MMR, and Varicella titers (along with the QuantiFERON blood test for TB), prior to being scheduled to begin orientation. MONITOR: All new employees will be sent for a post-hire physical examination, to include obtaining the titers for required immunizations, prior to first day of	01/17/2017

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	number IC.01.01.01, effective March 2016 and revised 11/1/16, indicated under A. Practice Guidelines, in section 3.: "...Upon employment the following employee health activities will occur: a. Health history...c. Review of Hepatitis B status. Employee will be offered Hepatitis B vaccination if previously not vaccinated. d. Titers obtained for MMR (measles, mumps, rubella) and Varicella with pre-hire physical...". 2. Review of the health file for LPN N2, who was hired 4/8/15, indicated there was no pre-hire physical in the file. 3. At 11:00 AM on 11/29/16, interview with staff member #54, the human resources director, confirmed that: A. Even though the policy listed in 1. above was first implemented in March 2016, pre hire physicals were required prior to that time and N2 should have had one in their file. B. It is unknown why there is no physical evaluation present in the health file for N2.		employment. This will be monitored prior to new employee being scheduled for first day of orientation. Annual review of all employee health records will be conducted to keep immunizations up-to-date. RESPONSIBLE PARTY: Employee Health Nurse	
S 0330 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K) (c) The governing board is responsible for managing the hospital. The governing board shall do the			

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	following: (6) Require that the chief executive officer develops policies and programs for the following: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.			
	Based on document review and interview, the governing board failed to ensure the following of the TB (tuberculosis) plan/policy for 5 of 10 personnel files reviewed(staff members N1, N3, N4, N7 and N8, and related to two step TB testing N6, N7 and N8). Findings Include: 1. Review of the policy "Annual 2016 Tuberculosis Control Plan", reference/policy number CDC; IC.02.01.01 EP 3; IC.02.03.01, indicated on page two under "Definitions": "Tuberculin Skin Test (TST) - a diagnostic aid for finding M tuberculosis infection...the area is examined for induration by palpation 48-72 hours after the injection." 2. Review of personnel health files indicated:	S 0330	All newly hired staff will either complete a 2 step TST upon hire, or will have the QuantiFERON blood test for TB done, along with their pre-hire blood-work. The 2017 TB Exposure Control Plan has been revised, reviewed and approved through the Governing Board level to reflect this practice. MONITOR: 2 Step TST testing or TB Blood test to be performed upon hire. TST Testing will be read between 48 to 72 hours after it is injected and documented with date/time and nurse reading results. RESPONSIBLE PARTY: Human Resources to order the post-hire testing to be performed, which includes the TB blood test. The Employee Health Nurse will perform the 2 Step TST tests, as needed and will also read and document results, within the given timeframe (48-72 hours).	01/17/2017

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	A. N1 had a TST given at 11:30 AM on 10/25/16 that was read at 8:00 AM on 10/27/16 which was earlier than 48 hours as required by policy. B. N3 had a TST given at 8:00 AM on 10/25/17 (sic) that was read on 10/27/16, but lacked a time of the reading to determine if this occurred within the 48 to 72 hour time frame required per facility policy. C. N4 had a TST given on 10/25/16 at 8:20 AM that was read on 10/27/16, but lacked a time of the reading to determine if this occurred within the 48 to 72 hour time frame required per facility policy. D. N7 had a TST given on 10/28/16 and read on 10/31/16 that lacked a time given and a time read to be able to determine if this occurred within the 48 to 72 hour time frame required per facility policy. E. N8 had a TST given on 10/11/16 that was read on 10/13/16 but lacked a time given and a time read to be able to determine if this occurred within the 48 to 72 hour time frame required per facility policy. 3. At 11:00 AM on 11/29/16, interview with the human resources director, staff member #54, confirmed that TB tests given to the staff in 2. above were not documented appropriately to be able to determine they were read within the			

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	window of 48 to 72 hours. 4. Review of the policy "Tuberculin (TB) Skin Testing", reference/policy number CDC, last reviewed/revised 5/2016, indicated under "Procedure": "...New Faculty/Staff: At the time of employment, during the initial Vibra Hospital immunization and screening evaluation,...shall receive two (2) mantoux 5 Tu TB Skin Tests given two (2) weeks apart ("two-step testing") unless: 1. A previously positive TB skin test reaction is reported, OR 2. Evidence of completion of adequate therapy for active TB is reported, OR 3. One (1) negative B (sic) skin test within the past twelve (12) months with proper documentation of such negative results...". 5. Review of personnel files indicated: A. Staff member N6 was hired 10/7/16 and only had one TB test present in the file that was dated 4/21/16 and read 4/23/16. There was no second step TB test noted. B. Agency nurses N7 and N8 had only October 2016 TB tests (see 2.. D. and E. above) in their files and no documentation of a previous negative TB test or that a second of two step testing was performed.			

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	6. At 11:00 AM on 11/29/16, interview with the human resources director, staff member #54, confirmed that it could not be determined that two step testing occurred for employees N6, N7 or N8, as required per facility policy.			
S 0356 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(4)(A)(B) (i)(ii)(iii) (d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following: (4) Ensure either of the following: (A) If the hospital does provide community emergency services to the public, it shall provide that service in compliance with 410 IAC 15-1.6-2 (B) If the hospital does not provide community emergency services to the public, it shall do the following: (i) Have written medical staff policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. (ii) Provide immediate lifesaving measures within the scope of services available to all persons who appear for emergency care which includes, but is not limited to, the following:			

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	(AA) Timely assessments. (BB) Stabilization. (CC) Treatment prior to transfer. (iii) Arrange for transfer of the patient, with copies of records of treatments provided, to another hospital which does provide appropriate clinical services. Based on document review and interview, the governing board failed to ensure policies and procedures for treatment of patient emergencies including transfer (along with copies of the records of care provided) to another hospital with the capability to provide appropriate clinical services in the event of an emergency for 1 facility. Findings include: 1. The policy/procedure Code Blue (revised 11-16) indicated the following: "In the absence of a physician in-house, the Code Team Leader will run the code per ACLS (Advanced Cardiac Life Support) Protocol... The Team Leader will coordinate the follow up care or transfer of the patient/victim..." It could not be determined if another policy/procedure indicating the process for an emergency transfer of a patient to the ED (emergency department) of the host hospital was available or if any medical staff or other personnel associated with the host hospital were	S 0356	The Chief Clinical Officer has been assigned to revise the "Code Blue" policy to incorporate the Transfer process, when a patient needs to be transferred to a higher level of care. The CCO and Staff Educator worked on creating the Discharge/Transfer Report to capture the information needing to be communicated to the next level of care, if the patient is not going home, following this hospital stay. MONITOR: HIM will conduct 100% audit of charts upon discharge to ensure these reports were completed by the discharging/transferring nurse (original goes with the patient, with a copy remaining in the patient's medical record). RESPONSIBLE PARTY: CCO responsible to ensure all clinical staff complete this form upon transfer to a higher level of care or discharge to a lower level of care (not to be completed for a patient being discharged to home).	02/03/2017

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	expected to respond to a patient code blue emergency at the facility. 2. At 1120 hours and 1430 hours on 11-29-16, the director of quality, staff A3, and the administrator, staff A1 were requested to provide a policy/procedure for routine and/or emergency patient transfers and none was provided prior to exit. 3. At 1525 hours on 11-29-16, the director of quality, staff A3 confirmed no transfer policy or other documentation was available and confirmed the Code Blue policy/procedure failed to indicate how and when a patient in acute decline shall be transported to the ED (emergency department) of the host hospital, failed to indicate if any medical staff from the host facility were expected to respond to a code blue emergency at the facility, and failed to indicate the copies of the medical record (MR) to be provided to the receiving facility at the time of emergency patient transfer.			
S 0394 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3) (f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board			

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	shall insure the following: (3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided. Based on document review and interview, the facility failed to maintain a list of all contracted services, including the nature and scope of services provided for 17 contracted services. Findings include: 1. Review of the list of contracted services received on 11-28-16 from the administrator, staff A1 indicated an entry titled purchased services agreement associated with the host hospital and no documentation indicated the individual services provided by agreement with the host facility. 2. Review of administrative documentation indicated the host hospital provided 14 services by agreement including patient dietary services, general maintenance, radiologic, x-ray and diagnostic imaging services, electrocardiogram and echography services, professional services for a medical director of Infection Prevention and Control, professional services for a licensed physician presence on scene in the event of a patient code blue	S 0394	The Chief Executive Officer is working with corporate to review the existing list of contracted services, in order to delete those services no longer being used in this location and add services to the list, if they are found to be not included on the list. He does not have direct access to this list and is waiting to work this detail out with corporate to make our list concise and accurate. MONITOR: List will be monitored and updated on an annual basis and as needed, if services change during the year. RESPONSIBLE PARTY: Chief Executive Officer with the assistance of the Administrative Assistant, to keep records up-to-date.	02/03/2017

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	emergency, surgical services, biomedical services and continuing education services. Additional services identified as provided by the host facility included general waste and medical waste disposal, automatic fire detection and suppression, fire extinguisher services, and building environmental services (heating, cooling, and air handling maintenance). 2. Review of the list of contracted services indicated two hemodialysis providers (CS15 and CS16, two laundry providers (CS17 and CS18) and a biomedical engineering provider (CS19). 3. Facility documentation indicated hemodialysis services were currently provided by CS16, laundry services were provided by CS18, and biomedical engineering services were provided by CS20 (not identified on the list of contracted services) 4. At 1120 hours on 11-29-16, the director of quality, staff A3 confirmed the list of contracted services lacked the indicated services and confirmed the list had not been maintained.			
S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT			

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	410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to ensure that all services were evaluated and reviewed through the Quality Assessment and Performance Improvement Program (QAPI) program for 4 contracted services. Findings include: 1. Review of the 2016 Performance Improvement Plan (approved 3-16) indicated the following: "All contracts are evaluated based on utilization and renewal, but those involved with the provision of patient care, treatment, and services are evaluated quarterly to monitor the quality of their services." 2. Review of administrative documentation indicated the host hospital provided surgical services, radiologic, x-ray and diagnostic imaging services,	S 0406	Biomedical Engineering Provider added to the Quality Reporting for 2017. Quality Management of Host Hospital Services: 1. Continue to monitor Turn-Around Times for Parkview Laboratory Services 2. The remaining services, including surgical services, radiology, X-Ray, diagnostic imaging, EKG and EEG will be followed up immediately should an issue arise, which does not meet the expected performance for the service. This will be done on an as needed basis. NOTE: No issues were identified or reported to Clinical Services or the Director of Quality in the above noted areas for 2016. MONITOR: Minimally Quarterly (and more often if data is made available to the facility) to report in the quarterly/monthly Quality Meetings RESPONSIBLE PARTY: Director of Quality	01/25/2017

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	and electrocardiogram and echography services by agreement. 3. Review of preventive maintenance documentation indicated the service was provided by the biomedical engineering provider (CS19). 4. Review of the QAPI committee minutes on 11-18-15, 1-28-16, 2-25-16, 3-31-16, 4-28-16, 5-30-16, 6-30-16, 7-28-16, 8-25-16 and 9-22-16 failed to indicate the identified contracted services were being evaluated through the QAPI program. 5. At 1120 hours on 11-29-16, the director of quality, staff A3 confirmed that the QAPI documentation lacked evidence of monitoring and reporting for the identified services provided by agreement.			
S 0556 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.			

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

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	Based on document review, observation and interview, the infection control committee failed to ensure an active, effective infection control program was implemented related to failure to follow their Infection Control Plan and with failure to implement standards of practice for C-Diff patients in contact precautions. Findings Include: 1. Review of the Infection Control Plan, reference/policy number IC.01.01.01, approved by the infection control committee on 4/16, indicated on page 11 in item 7.0 "High Risk Patients and Practices:", "As identified by the Risk Assessment for the year, the following were identified as high risk: 7.1 Daily evaluation of the central line 7.2 Daily evaluation of continued need for urinary catheter 7.3 Patients with CDI (C-Difficile)...". 2. At 11:40 AM on 11/29/16, interview with the infection preventionist, staff member #58, confirmed that there has been no daily evaluation done of central lines, daily evaluation of the continued need for urinary catheters or evaluation of C-Diff patients as stated in the Infection Control Plan as expected to be performed. 3. While on tour of the East and West	S 0556	We instituted Enhanced Contact Precautions for C-Diff and CRE patients (use soap, water and friction for 15 seconds, instead of using alcohol based sanitizers), in conjunction with the time the host hospital enhanced their policy (approx. one month ago). Isolation Precautions policy needs to be revised to include Enhanced Contact Precautions with the use of the "Enhanced Contact Precautions" sign to hang outside of the patient's room. In HMS patient care, there is a "criteria for extended CL use" and "criteria for indwelling urinary catheter use" These automatically populate, but staff are not using them. The CCO is reviewing these "criteria for extended use" for both CL and Foley catheter use with the clinical staff at the Staff Meetings next week (week of 2/20/2017) and then let them know to do it once a shift. C-Diff patients, once placed in the Enhanced Precautions for C-Diff during their current hospitalization, remain in the Enhanced Precautions for the remainder of their stay here. MONITOR: Nursing Supervisors to spot check HMS charting to ensure completion of the "Criteria for Extended Use for CL's and Foleys". Additional monthly auditing to be done by assigned nursing staff, as per the CCO. RESPONSIBLE PARTY: CCO and Nursing Supervisors	01/27/2017

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	nursing units at 10:30 and 11:30 AM on 11/28/16, it was observed that all of the Contact Precaution signs were green and indicated the need for persons entering the room to utilize hand sanitizer prior to gloving and after removing gloves. 4. Review of the document "Daily Staffing Report" for 11/28/16, indicated two patients, in rooms 552 and 554, had C-Diff as the reason for isolation/contact precautions. 5. The standard of practice, per the Lippincott Manual of Nursing Practice 10th edition, on page 1087, reads: "Clostridium difficile-Associated Disease (CDAD)...Transmission...2. The use of alcohol hand gels is not recommended following care of a patient with CDAD. Staff and visitors should wash their hand (sic) with soap, warm water, and friction for 15 seconds to perform adequate hand hygiene...". 6. At 11:40 AM on 11/29/16, interview with the infection preventionist, staff member #58, confirmed that: A. C-Diff contact precautions are not carried out any differently at this facility than for other MDRO (multi drug resistant organisms). B. Some studies indicate there is no substantive proof that hand gels/foams			

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	are not as effective as hand washing with soap and water after caring for C-Diff patients. 7. No other documents were provided prior to exiting the facility.			
S 0596 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (iii) Cleaning, disinfection, and sterilization. Based on document review and interview, the infection control committee failed to approve the chemicals used to clean and disinfect the facility. Findings Include: 1. Review of the 2015 and 2016 Infection Control meeting minutes indicated there was no documentation of approval of chemicals and	S 0596	Since the ISDH survey, the list of "Hospital Approved Disinfectants" was presented/reviewed and approved by the Infection Control Committee, Quality Committee and by the Medical Executive Committee. All EVS policies will be routinely submitted to the Infection Control Committee for review/approval from here on. MONITOR: All new/revised/reviewed policies will be monitored by the DQM, with	01/17/2017

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	cleaning/disinfecting products used by the EVS (environmental services) staff. 2. At 9:45 AM on 11/29/16, interview with the EVS director, staff member #57, confirmed that: A. A different product had been utilized prior to using the Diversey products the facility is currently cleaning and disinfecting with. B. It was unknown when the switch occurred, or if the infection control committee approved the current products. 3. At 11:40 AM on 11/29/16, interview with the infection preventionist, staff member #58, confirmed that it was unknown if, or when, the infection control committee approved products used by the EVS staff to be certain that proper disinfection is occuring within the facility.		those policies regarding "Hospital Approved Disinfectants", to be sent to the Infection Control Committee Meeting, Quality Council and then the Medical Executive Committee for approval. RESPONSIBLE PARTY: Director of Quality, Infection Preventionist	
S 0606 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:			

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	(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review and interview, the infection control committee failed to ensure that an active, effective employee health program was implemented in regard to communicable disease history for 5 of 10 employee files reviewed, employees N2, N4, N5, N6 and N7. Findings Include: 1. Review of the policy "Employee Health Services", reference/policy number IC.01.01.01, effective March 2016 and revised 11/1/16, indicated under A. Practice Guidelines, in section 3.: "...Upon employment the following employee health activities will occur: a. Health history...c. Review of Hepatitis B status. Employee will be offered Hepatitis B vaccination if previously not vaccinated. d. Titers obtained for MMR (measles, mumps, rubella) and Varicella with pre-hire physical...". 2. Review of employee files indicated: A. N2 was hired 4/8/15 and had signed	S 0606	This process had already been addressed prior to the ISDH survey, regarding all new hires. Employee Health Nurse is contacting all other employees, whose Employee Health file does not contain proof of immunizations, to either provide proof of immunization for their EH file, or they are being sent to Parkview Occupational Health to have the blood work done to obtain the titers missing from their file. The completion of this process will occur around mid February, because it takes one week following the blood-draw to obtain the actual results for the files. Those staff failing to meet this deadline will be followed up by HR for failing to comply with hospital policy. MONITOR: 100% audit performed initially in 12/2016 and will be performed annually to ensure all paperwork is up-to-date to include updated immunizations RESPONSIBLE PARTY: Employee Health Nurse	02/15/2017

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	a document titled: "Hepatitis B Vaccine Acceptance Request and Consent Form" on 4/8/15 indicating a request of the "Hepatitis B Vaccine Series", but had no documentation in the file that the series had ever begun. B. N4 was hired 7/9/14 and lacked documentation in the file for Rubella, Rubeola and Varicella. C. N5 was hired on 7/7/15 and lacked documentation of Rubeola and Varicella status in the file. D. N6 was an agency nurse who first worked on 10/7/16 and lacked documentation of Rubella and Hepatitis B status in the file. E. N7 was an agency nurse who first worked on 11/1/16 and lacked documentation of Rubella and Rubeola in the file. 3. At 11:00 AM on 11/29/16, interview with staff member #54, the human resources director, confirmed that: A. The MMR and Varicella titers, as listed in the policy in 1. were not being done prior to March 2016 and so far the facility has not gone back and brought previously hired employees up to current standards making their immune status unknown at this time. B. Employees N6 and N7 were hired after the policy was implemented and don't have the information required by			

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	policy. C. It is unknown why staff member N2 signed a consent for the Hepatitis B Vaccine 4/8/15 and there is no documentation of this series having been started as requested.			
S 0788 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(9) (i) Emergency service records shall document and contain, but not be limited to, the following: (9) Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be recorded. Based on document review and interview, the facility failed to ensure that a transfer form was completed and present in the medical record for 1 of 1 transfer record reviewed(Patient #6). Findings Include: 1. Review of the Rapid Response Team Activation policy, policy number 2008.36, last revised on 12/14, indicated "...The nurse administrator will facilitate bed placement whenever needed...".	S 0788	Review of discharge/transfer checklist has begun by the Chief Clinical Officer and the Staff Educator. Checklist to be reviewed to ensure it provides a user friendly guide for compiling the discharge/transfer paperwork, being sent with the patients to a lower level or higher level of care, as required by the patient's condition. Once the review and formatting is complete, we will send this checklist to the printer to make it into a 2 copy document, with one copy remaining on the chart upon patient's discharge/transfer out of	02/03/2017

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	2. Review of the document "Dicharge (sic) Packet" indicated 24 items to include in a patient discharge packet. 3. Review of the medical record for patient #6 indicated there was no transfer form/record for this patient who went to a higher level of care for GI (gastro intestinal) bleeding on 10/15/16. 4. At 2:30 PM on 11/29/16, interview with the quality director, staff member #52, confirmed that: A. Patients sent to a higher level of care are considered "discharged", not transferred. B. Only patients who are sent to a higher level of care after a code or rapid response event are considered transferred, and patient #6 was not a code or rapid response patient. C. There is no transfer policy at the facility, the rapid response policy meets this purpose. D. The facility has no transfer form and no way for the facility to be able to show what medical records were sent with patient #6, who went to a higher level of care, to assure continuity of care. 5. At 3:25 PM on 11/29/16, interview with the director of medical records, staff member #56, confirmed that the nursing unit uses the checklist, as listed in 2.		the facility. NOTE: The documents (checklist and discharge/transfer report) have been created and are being printed at the printer as of 2/13/2017. MONITOR: All Discharge Charts will be audited 100% by HIM to ensure 100% compliance with this new process. Nursing Supervisors will actively provide concurrent auditing during each discharge process to ensure accurate use of the new forms. RESPONSIBLE PARTY: CCO and Nursing Supervisor on duty	

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	above, when patients are sent to another facility, but a copy of the checklist is not kept for the patient's record at this facility so that it cannot be determined which portions of the medical record may have been provided to a higher level of care for continuity of patient care.			
S 0912 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by			

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	hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. Based on document review, observation and interview, the nursing supervisor failed to ensure the implementation of the policy related to glucometer control solutions for 2 units and the policy related to a requirement for consent for blood transfusions for 1 of 1 patient who received a blood transfusion,(Patient #6). Findings Include: 1. Review of the policy Blood Glucose Monitoring, reference/policy number WT.01.01.01, last reviewed/revised 3/16, indicated on page two under Reagent Storage Requirements that "...The test strips bottle and control solution vials should be dated upon opening. Discard any used portion 3 months after opening. Do not use after the expiration date printed on the vial label." 2. At 10:30 AM on 11/28/16 while on tour of the West nursing station in the company of the CEO (chief executive officer), staff member #50, it was observed that 3 vials of glucometer control solutions (one vial of #1 and 2 vials of #2) were not dated when opened	S 0912	This was assigned to the Chief Clinical Officer and the Staff Educator to ensure all staff are educated and held accountable to follow the policies below: "Blood Glucose Monitoring" "Blood Transfusion" Nursing Supervisor to check dates on the reagent solutions as they conduct their unit rounds each shift. Nurses to be held accountable for ensuring that the consent is in place when the 2 nurses confirm all aspects leading up to administering the blood have been completed (i.e. consent in place, blood type and patient ID are correct). MONITOR: Reagent solutions will be audited for date opened daily, when the nursing supervisors conduct their hand off/ EOC Rounds/Report. Consents will be monitored monthly to ensure correct process is followed with each blood transfusion administered. RESPONSIBLE PARTY: CCO, Nursing Supervisors, and RN's	01/27/2017

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	with a 3 month expiration date. 3. At 10:40 AM on 11/28/16, staff member #50 confirmed that the three vials of control solutions had not been marked with a 3 month expiration date after they had been opened. 4. At 11:30 AM on 11/28/16 while on tour of the East nursing station in the company of the CEO, staff member #50, it was observed that control solutions #1 and #2 had no date marked on the vials to indicate when they had been opened and when the 3 month expiration date would occur, or had occurred. 5. At 11:30 AM on 11/28/16, staff member #50 confirmed the glucometer control solutions had not been marked when opened and it could not be determined when the 3 month expiration date would occur. 6. Review of the policy Blood Transfusion, policy number PC.05.01.09, last revised 11/16, indicated under the title Pre-Transfusion, "Verify informed consent is complete and on the chart." 7. Review of the medical record for patient #6 indicated they had received blood transfusions and lacked a copy of a blood consent form in the medical record.			

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	8. At 3:25 PM on 11/29/16, interview with the medical records manager, staff member #56, confirmed that no consent for blood transfusion could be found for patient #6, even though they were noted as having blood transfusions while a patient at the facility. 9. Copies of the blood transfusion forms for patient #6 were requested but not received prior to exiting the facility.			
S 0952 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on document review and interview, the governing board failed to ensure blood transfusion competency for 5 of 5 agency and dialysis nurses, N6, N7, N8, N9 and N10. Findings Include: 1. Review of the policy "Blood	S 0952	All dialysis and agency nurses will be required to complete the nursing competency for Blood Administration/ transfusions. Staff Educator will be contacting Fresenius (our contracted dialysis service) to provide them with a mandatory Blood Transfusion Education Packet, post test and Nursing Competency for Blood	01/27/2017

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	Transfusion", policy/reference number PC.05.01.09, last revised 11/16, indicated under "Policy": "Registered Nurses will administer blood transfusion according to procedure...". 2. Review of agency RN files N6, N7 and N8 and contracted dialysis nurses N9 and N10 files indicated none had documentation of orientation/competency for performing blood transfusions. 4. At 1:30 PM on 11/29/16, interview with the scheduler and person responsible for agency/dialysis nursing files, staff member #55, confirmed that: A. RNs give blood at the facility. B. All facility RN files had annual competency in blood transfusion documented, but the agency and dialysis nursing files lacked such documentation.		Administration. All nurses sent to Vibra to provide dialysis support must have this completed paperwork in their files, prior to providing service to our patients. The Staff Educator will also meet these nurses 1 on 1 to expedite getting this completed as soon as possible. All agency nurses will receive this training and testing/competency during their hospital/nursing orientation period. MONITOR: All agency nurses must provide a Blood Transfusion competency with their pre-hire paperwork or complete the Blood Transfusion Competency during the agency orientation. All new agency nurse education files to be audited for completion prior to being assigned on the schedule. RESPONSIBLE PARTY: Staff Educator and the Staffing Coordinator	
S 1168 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged			

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	at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on document review, observation and interview, the facility failed to ensure that defibrillator inspection and testing was performed according to the manufacturer's recommendations for 1 occurrence. Findings include: 1. Review of the facility Physio-Control LifePak 20E Operating Instructions (2010 edition) Appendix D indicated the Operator's Checklist of manufacturer's recommendations for daily inspection and testing of the defibrillator. 2. During a tour on 11-28-16 at 1128 hours, a Lifepak 20 monitor/defibrillator was observed in the east side nursing station. The document Crash Cart Checklist East located on top of the Code Cart failed to indicate that the defibrillator checks were performed in accordance with the manufacturer's recommendations listed on the Operators Checklist in appendix D. 3. At 1100 hours on 11-29-16, the chief clinical officer, staff A2 confirmed that the Crash Cart Checklist failed to ensure that the Lifepak 20 defibrillator checks	S 1168	The Chief Clinical Officer is creating a revised defibrillator checklist, to include manufacturer's recommendations for testing. Checklist to be reviewed in Staff Meetings next week, then they will be put into use. MONITOR: Weekly audits of Crash Cart checklists are conducted weekly, which includes defibrillator checklist and required shift change signatures for the incoming and outgoing nurses. RESPONSIBLE PARTY: CCO and Nursing Supervisors	01/27/2017

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	152027	A. BUILDING 00 B. WING	11/29/2016

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	were being performed per manufacturer's recommendations.			
S 1172 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on document review, observation and interview, the facility failed to ensure the cleanliness of refrigerators in the staff pantry, the East and West unit patient pantry area and medication refrigerators, and failed to ensure cleanliness of the code cart on the East nursing station. Findings Include: 1. Review of the policy Cleaning Staff Break Room, policy number 671.4, last revised/reviewed 9/2016, indicated under Procedure: "...Refrigerators and microwaves are the responsibility of EVS	S 1172	EVS Manager developed a Plan of Correction for cleaning ALL refrigerators and daily audit for unreported spills and the department now has a Cleaning Schedule to work from.. High-Dusting conducted daily through-out the unit and audited weekly. MONITOR: EVS audits unit daily to include checking refrigerators and items needing high-dusting. RESPONSIBLE PARTY: EVS Manager	01/27/2017

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	(environmental services)...". 2. Review of the document "Refrigerator Cleaning Log 2016", for the staff break room, indicated the refrigerator had last been cleaned on 11/13/16. 3. At 10:25 AM on 11/28/16 while on tour of the staff break room in the company of the CEO (chief executive officer), staff member #50, it was observed that there were crumbs/debris present under the two vegetable drawers and in the gasket of the refrigerator along with dried liquid and debris on the shelves of the door. 4. At 10:25 AM on 11/28/16, staff member #50 confirmed the condition of the refrigerator, as listed in 3. above, and that EVS staff clean the facility refrigerators. 5. Review of the "Refrigerator Cleaning Schedule 2016" for the West unit pantry refrigerator indicated the appliance was last cleaned on 11/26/16. 6. At 10:45 AM on 11/28/16 while on tour of the West nursing unit in the company of staff member #50, it was observed that there was an accumulation of dust on top of the pharmacy refrigerator/freezer located in the nursing			

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	station. 7. Staff member #50 confirmed the dust presence on the refrigerator/freezer on the West nursing unit at 10:45 AM on 11/28/16 8. At 11:25 AM on 11/28/16 while on tour of the East unit in the company of staff member #50, it was observed that the pantry refrigerator had crumbs/debris in the vegetable drawers and under them, as well, along with dried liquid spills on the lower shelf of the refrigerator and the lower door shelf. 9. At 11:28 AM on 11/28/16 while on tour of the East Unit nursing station in the company of staff member #50, it was observed that the back of the Lifepak 20 defibrillator had an accumulation of dust present. 10. At 11:28 AM on 11/28/16, staff member #50 confirmed the conditions noted in 8. and 9. above. 11. At 10:00 AM on 11/29/16, interview with the EVS manager, staff member #57, confirmed that: A. The refrigerators were the responsibility of the EVS staff. B. Another policy, "Cleaning Nurses Station", policy number IC.02.02.01,			

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	does not specifically list the pantry refrigerators in the East and West nursing units, or the pharmacy refrigerators, as a requirement for cleaning by EVS, but it is expected that EVS staff will clean these on a routine basis. C. The policy listed in B. above indicates EVS staff are to "Wipe down counters, chairs, outsides of cabinets, telephones and ect (sic), with a hospital approved germicidal solution. Dust behind computer monitors...", but does not list the code/crash cart as a specific responsibility of the EVS staff.			
S 1186 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients,			

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	personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. Based on document review and interview, the safety program failed to follow its fire safety management plan and ensure that quarterly fire drills were performed on all shifts for 1 of 4 quarters in 2016 (2nd quarter). Findings include: 1. The policy/procedure 2016 Annual Fire Safety Management Plan (approved 3-16) indicated the following: "Monitoring activity relative to fire safety will be reported through the Environment of Care (EOC) committee to the Quality Council... (and Governing Board).... Drills will be conducted once per shift per quarter according to policy...". 2. Review of EOC minutes dated 1-19-16, 3-1-16, 5-3-16, 7-5-16, 9-6-16 and 11-1-16 failed to indicate any fire drills performed in 2016 were reported and/or reviewed. 3. Review of 2016 fire drill documentation failed to indicate a fire drill was performed on the day shift from 0730 hours to 1930 hours during the second quarter (April, May & June) of 2016.	S 1186	Parkview Randallia Hospital (host hospital) carries out the quarterly fire drills for Vibra Hospital of Fort Wayne. Our Plant Operations Manager notified the Parkview staff of the omitted drill on day shift, 2nd Quarter of 2016. Increased communication needs to occur between host hospital and Vibra Hospital of Fort Wayne's Plant Operations Manager, to ensure fire drills are conducted as scheduled (remaining in compliance with regulation). Our Plant Operations Manager is aware that all fire drills need to be reported at the EOC Meetings and documented in the minutes, to include date/time(if known) and shift. MONITOR: Plant Operations Manager will audit monthly to ensure all fire drills are conducted as per regulations. RESPONSIBLE PARTY: Plants Operations Manager	01/01/2017

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	4. At 1510 hours on 11-29-16, the administrator, staff A1 confirmed that no fire drill documentation for the 2nd quarter day shift was available.			
S 1198 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(G) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (G) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies. Based upon document review and interview, the facility failed to follow its emergency preparedness plan and ensure its staff participated in a minimum of 2 disaster preparedness drills with community, state and federal emergency and disaster preparedness agencies. Findings include: 1. Review of the 2016 Emergency Preparedness Plan (approved 3-16) indicated the following: "At least two (2) actual disaster events or drills will be conducted each year... updates will be provided during the course of the year, at	S 1198	For 2016, we had 1 actual disaster event in 3/2016 and one tabletop disaster drill, occurring in 12/2016; thereby meeting this requirement. The Plant Operations Manager will report all of these events/drills in the EOC Committee Meetings. The DQM stresses the importance of identifying staff participation during these events and to include these details in the EOC Minutes. MONITOR - Actual Disaster Events will be reported through EOC Committee Meetings. A minimum of two disaster events work-ups need to be done annually and table top disaster drills will be conducted, if no real	01/01/2017

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	the EOC (environment of care) committee meetings..." 2. Review of EOC minutes dated 1-19-16, 3-1-16, 5-3-16, 7-5-16, 9-6-16 and 11-1-16 failed to indicate facility staff participated in any disaster drills conducted by the host hospital and the 5-3-16 and 7-5-16 EOC minutes indicated the following: "When ... (the host hospital)... does drills we should do them also. When they have severe weather drills no one will know what they need to do..." 3. At 1315 hours on 11-29-16, the administrator, staff A1 confirmed that no other documentation indicating staff participation with District 3 disaster management events or other disaster drill activity was available.		events occur during the year. Events will be reviewed twice per quarter and then reported to EOC Committee Meeting, if they fall into the disaster event category. RESPONSIBLE PARTY - Plants Operations Manager.	