STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	152028		04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF NORTHWESTERN INDIANA	9509 GEORGIA ST CROWN POINT, IN 46307

(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 Federal hospital complaint investigation. Complaint number: IN00195754 Substantiated; Federal deficiency related to allegations is cited. Deficiency unrelated to the allegations is cited. Date of survey: 04/7/2016 Facility number: 012131 QA: cjl 04/19/16	A 0000		
A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review, observation and interview, nursing failed to ensure a safe setting for 4 of 9 (#p4, #p6, #p8 and #p9) medical records reviewed of patients assessed as high fall risk. Findings included:	A 0395	The Fall Prevention Management Program was revised to reflect the current Morse Scale of 51 or greater as high risk for fall per the electronic medical record (Completed 4/11/16). The Medical Executive Committee approved the revised Fall Prevention Management Program (Completed 4/13/16). The Fall	07/07/2016

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	1. Review of policy Fall Prevention & Management Program stated, "All patients admitted to the inpatient setting will be assessed for fall 'risk' using the Modified Morse Fall Risk on admission, each shift, and change in status of the patient, and prior to patient discharge. Safety devices will be initiated when indicated according to policy as soon as possible once the patient is assessed as being 'at risk' for falling. Standard Fall Prevention Interventions: Interventions suggested for implementation in this procedure include both standard and high risk interventions specific to the patient's fall risk score. High Risk Fall Prevention Interventions: Use for those who score High Risk on the Fall Risk Assessment (>45 on Modified Morse Fall Risk Assessment). Consider use of safety technology for fall prevention: Bed and chair alarm". The policy was last revised December 2014. 2. Review of Bed Alarms policy N-27.00 stated, "Patients at risk for falls will be assessed by a licensed nurse on admission and as needed for use of a bed/chair alarm as part of falls prevention program. Licensed nurse will initiate use of alarm in patient's Potential Injury due to Falls Care Plan." The policy was last revised March 2015.		Prevention Management Program was uploaded to the Governing Board Central, a repository for Governing Board data on Vibranet (Completed 4/29/16). The Chief Clinical Officer and/or Designee began education with the nursing staff on the post-fall fall huddle debrief procedure on April14, 2016 (to be completed by 5/7/16). The Chief Clinical Officer and/or Designee will educate 100% of the nursing staff on the following policies and/or procedure (to be completed by 6/7/16). ·Bed Alarms ·Fall Prevention Management Program ·Enteral Nutrition Formula Policy ·Post Fall Huddle Debrief Procedure The Chief Clinical Officer or Designee is responsible for compliance with thefollowing (to initiate by 6/7/16):1. Auditing 30 random medical records per week forcompliance. Random defined asalphabetical rotation of 30 patients per week.2. Review of Fall risk per Fall Prevention ManagementProgram.3. Review ofidentification of High Fall Risk on Care Plan.4. Review ofappropriate Fall prevention measures within the medical record.5. Validation ofactivation of bed alarm as identified in the Fall Risk assessment. The Chief Clinical Officer or Designee will review theresults of the weekly	

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	3. Review of medical records #p4, #p6, #p8 and #p9 indicated all four (4) patients were assessed as High Risk fall precautions: A. Patient #p4 medical record's Nursing Shift assessment - Flowsheet Detail, dated 4/7/2016, indicated Morse Fall Risk Score totaled 50.0. The medical record lacked documentation that bed and chair alarms were considered for use. B. Patient #p6 medical record's Nursing Shift assessment - Flowsheet Detail, dated 4/7/2016, indicated Morse Fall Risk Score totaled 60.0. The medical record lacked documentation that bed and chair alarms were considered for use. C. Patient #p8 medical record's Nursing Shift assessment - Flowsheet Detail, dated 4/7/2016, indicated Morse Fall Risk Score totaled 50.0. The medical record lacked documentation that bed and chair alarms were considered for use. D. Patient #p9 medical record's Nursing Shift assessment - Flowsheet Detail, dated 4/7/2016, indicated Morse Fall Risk Score totaled 75.0. The medical record lacked documentation that bed and chair alarms were considered for use. 4. Patient #p9 had an incident dated and		audits with the House Supervisors. The Chief Clinical Officer and the HouseSupervisors will develop a corrective action plan for non-compliantemployees (to be initiated by 6/7/16). The Chief Clinical Officer will report audit results to theQuality Assurance Performance Improvement and Medical Executive Committeesmonthly. The Chief Clinical Officer willcontinue auditing per the recommendation of the Quality Assurance, PerformanceImprovement Committee (to be completed by 7/7/16). The Director of Quality will report the audit results to theGoverning Board quarterly via the central secured repository, Governing BoardCentral (to be completed by 7/7/16). To prevent reoccurrence of the deficiencies, the ChiefClinical Officer or Designee will continue the random audit quarterly. The Chief Clinical Officer will present theaudit results along with the corrective action implemented (aggregate) to theQuality Assurance, Performance Improvement and Medical Executive Committeesquarterly, and to the Governing Board quarterly via the central securedrepository, Governing Board Central for review. The Chief Clinical Officer will continue auditing per the recommendationof the Quality Assurance, Performance	

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	time of 2/14/2016 at 10:00 PM. The incident report indicated the patient discovered date was on 2/15/2016 at 10:00 PM. The report indicated, "The patient was found on the floor by the nurse." The incident report noted the fall prevention interventions prior to the fall were: frequent visual checks, and call bell in reach. The incident report did not indicate the bed alarm was engaged for patient #p9 that had a fall precaution of high risk. 5. Patient #p9 had a second incident dated and time of 3/12/2016 at 4:30 AM. The incident report indicated, "At 0443 the assigned nurse reported that the patient was found on the floor by another nurse. The nurse stated she did not activate the bed alarm." The incident report noted the fall prevention interventions prior to the fall were: frequent visual checks, call bell in reach, personal items in reach, verbal reminders, ID'd as fall risk, light on in room, and low bed. The incident report did not indicate the bed alarm was engaged for patient #p9 that had a High Risk fall precaution. 6. At 1:40 PM on 4/7/2016, #p6 and #p9's rooms were observed with staff members #3 (CCO), #6 (RN Supervisor) and #5 (Plant Operations). #p6 and #p9's		Improvement Committee.	

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	beds were observed with bed alarms that were not on. 7. At 2:45 PM on 4/7/2016, staff member #1 (Director of Quality) indicated all patients of the hospital are assessed as universal fall precaution at a minimum; however, High Risk fall precaution shall be initiated when the assessment requires it.			
A 0724 Bldg. 00	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. Based on observation, document review, and interview, the hospital failed to ensure Abbott Nutrition ready-to-hang (RTH) and Hi-Cal Light nutritional supplements were stored properly in the nourishment room and the supply room. Findings included: 1. Review of Abbott Nutrition ready-to-hang (RTH) and Hi-Cal Light	A 0724	The nutritional supplements were relocated and stored perthe manufacturer's recommendations. (Completed 4/7/16) The Infection Control Committee met on April 27, 2016 to review the procedure of storing nutritional supplements properly in the nourishmentroom and supply room. The Dietician revised the Enteral Nutrition Formula policyto reflect storage per the manufacturer's recommendation (Completed	06/07/2016

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	nutritional supplements manufacturer's specification sheet stated, "Several vitamins are light sensitive and degrade with exposure to light. Prolonged exposure to high intensity light sources degrades the vitamins at a faster rate. Store product in the shipper as long as possible or store on covered shelves or in a closed cabinet prior to use." 2. At 2:50 PM on 4/7/2016, the nourishment room was observed storing four assorted Abbott Nutrition ready-to-hang (RTH) and Hi-Cal Light nutritional supplements on the counter that were exposed to the florescent lighting within the room: Jevity 1.5 Cal; Osmolite 1.0 Cal; and 2 Glucerna 1.2 Cal. 3. At 3:10 PM on 4/7/2016, the supply room was observed with a wired shelf storage rack storing approximately 150 assorted nutritional supplements manufactured by Abbott Laboratories. Each individual container was removed from their original carton that they were packed in and displayed on the wired shelving unit. The assorted containers of nutritional supplements product label indicated, "Contains light-sensitive nutrients." The 150 assorted nutritional supplements were observed exposed to the fluorescent lighting within the room.		4/28/16) An Ad Hoc Infection Control Committee reviewed and approvedthe revised Enteral Nutrition Formula policy. (Completed on 4/29/16) The Quality Assurance and Performance Improvement Committeewill review and approve the Enteral Nutrition Formula policy (May 9, 2016). The Medical Executive Committee will review and approve theEnteral Nutrition Formula policy (May 11, 2016). The approved Enteral Nutrition Formula will be uploaded tothe Governing Board Central, an online repository for Governing Board onVibranet (May 11, 2016). The Materials Management Department will audit compliance ofappropriate storage of nutritional supplements and report to the Environment ofCare Committee monthly.	

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	4. At 3:10 PM on 4/7/2016, staff member #8 (Dietician) indicated the Abbott nutritional supplements that are stored in the store room are not protected from the fluorescent lighting. The staff member indicated he/she instructed the store room clerk that the product should have been stored in the shipping cartons they were received in before they are used for the patient; however, this has not been implemented. The staff member indicated the light intensity degrades the vitamins in the supplements.			
S 0000 Bldg. 00	This visit was for a State hospital complaint investigation. Complaint number: IN00195754 Substantiated; State deficiency related to allegations is cited. Deficiency unrelated to the allegations is cited. Date of survey: 04/7/2016 Facility number: 012131	S 0000		

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	QA: cjl 04/19/16			
S 0610 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (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: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review, and interview, the hospital failed to ensure Abbott Nutrition ready-to-hang	S 0610	The nutritional supplements were relocated and stored perthe manufacturer's recommendations. (Completed 4/7/16)	06/07/2016

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	(RTH) and Hi-Cal Light nutritional supplements were stored properly in the nourishment room and the supply room. Findings included: 1. Review of Abbott Nutrition ready-to-hang (RTH) and Hi-Cal Light nutritional supplements manufacturer's specification sheet stated, "Several vitamins are light sensitive and degrade with exposure to light. Prolonged exposure to high intensity light sources degrades the vitamins at a faster rate. Store product in the shipper as long as possible or store on covered shelves or in a closed cabinet prior to use." 2. At 2:50 PM on 4/7/2016, the nourishment room was observed storing four assorted Abbott Nutrition ready-to-hang (RTH) and Hi-Cal Light nutritional supplements on the counter that were exposed to the florescent lighting within the room: Jevity 1.5 Cal; Osmolite 1.0 Cal; and 2 Glucerna 1.2 Cal. 3. At 3:10 PM on 4/7/2016, the supply room was observed with a wired shelf storage rack storing approximately 150 assorted nutritional supplements manufactured by Abbott Laboratories. Each individual container was removed		The Infection Control Committee met on April 27, 2016 toreview the procedure of storing nutritional supplements properly in the nourishmentroom and supply room. The Dietician revised the Enteral Nutrition Formula policyto reflect storage per the manufacturer's recommendation (Completed 4/28/16) An Ad Hoc Infection Control Committee reviewed and approvedthe revised Enteral Nutrition Formula policy. (Completed on 4/29/16) The Quality Assurance and Performance Improvement Committeewill review and approve the Enteral Nutrition Formula policy (May 9, 2016). The Medical Executive Committee will review and approve theEnteral Nutrition Formula policy (May 11, 2016). The approved Enteral Nutrition Formula will be uploaded tothe Governing Board Central, an online repository for Governing Board onVibranet (May 11, 2016). The Materials Management Department will audit compliance ofappropriate storage of nutritional supplements and report to the	

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	from their original carton that they were packed in and displayed on the wired shelving unit. The assorted containers of nutritional supplements product label indicated, "Contains light-sensitive nutrients." The 150 assorted nutritional supplements were observed exposed to the fluorescent lighting within the room. 4. At 3:10 PM on 4/7/2016, staff member #8 (Dietician) indicated the Abbott nutritional supplements that are stored in the store room are not protected from the fluorescent lighting. The staff member indicated he/she instructed the store room clerk that the product should have been stored in the shipping cartons they were received in before they are used for the patient; however, this has not been implemented. The staff member indicated the light intensity degrades the vitamins in the supplements.		Environment ofCare Committee monthly.	
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise			

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	and evaluate the care planned for and provided to each patient. Based on document review, observation and interview, nursing failed to ensure a safe setting for 4 of 9 (#p4, #p6, #p8 and #p9) medical records reviewed of patients assessed as high fall risk. Findings included: 1. Review of policy Fall Prevention & Management Program stated, "All patients admitted to the inpatient setting will be assessed for fall 'risk' using the Modified Morse Fall Risk on admission, each shift, and change in status of the patient, and prior to patient discharge. Safety devices will be initiated when indicated according to policy as soon as possible once the patient is assessed as being 'at risk' for falling. Standard Fall Prevention Interventions: Interventions suggested for implementation in this procedure include both standard and high risk interventions specific to the patient's fall risk score. High Risk Fall Prevention Interventions: Use for those who score High Risk on the Fall Risk Assessment (>45 on Modified Morse Fall Risk Assessment). Consider use of safety technology for fall prevention: Bed and chair alarm". The policy was last revised December 2014.	S 0930	The Fall Prevention Management Program was revised to reflect the current Morse Scale of 51 or greater as high risk for fall per the electronic medical record (Completed 4/11/16). The Medical Executive Committee approved the revised Fall Prevention Management Program (Completed 4/13/16). The Fall Prevention Management Program was uploaded to the Governing Board Central, a repository for Governing Board data on Vibranet (Completed 4/29/16). The Chief Clinical Officer and/or Designee began education with the nursing staff on the post-fall fall huddle debrief procedure on April14, 2016 (to be completed by 5/7/16). The Chief Clinical Officer and/or Designee will educate 100% of the nursing staff on the following policies and/or procedure (to be completed by 6/7/16). ·Bed Alarms ·Fall Prevention Management Program ·Enteral Nutrition Formula Policy ·Post Fall Huddle Debrief Procedure The Chief Clinical Officer or Designee is responsible for compliance with thefollowing (to initiate by 6/7/16): 1. Auditing 30 random medical records per week forcompliance. Random defined asalphabetical rotation of	07/07/2016

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	2. Review of Bed Alarms policy N-27.00 stated, "Patients at risk for falls will be assessed by a licensed nurse on admission and as needed for use of a bed/chair alarm as part of falls prevention program. Licensed nurse will initiate use of alarm in patient's Potential Injury due to Falls Care Plan." The policy was last revised March 2015. 3. Review of medical records #p4, #p6, #p8 and #p9 indicated all four (4) patients were assessed as High Risk fall precautions: A. Patient #p4 medical record's Nursing Shift assessment - Flowsheet Detail, dated 4/7/2016, indicated Morse Fall Risk Score totaled 50.0. The medical record lacked documentation that bed and chair alarms were considered for use. B. Patient #p6 medical record's Nursing Shift assessment - Flowsheet Detail, dated 4/7/2016, indicated Morse Fall Risk Score totaled 60.0. The medical record lacked documentation that bed and chair alarms were considered for use. C. Patient #p8 medical record's Nursing Shift assessment - Flowsheet Detail, dated 4/7/2016, indicated Morse Fall Risk Score totaled 50.0. The medical record lacked documentation that bed and		30 patients per week. 2. Review of Fall risk per Fall Prevention ManagementProgram. 3. Review ofidentification of High Fall Risk on Care Plan. 4. Review ofappropriate Fall prevention measures within the medical record. 5. Validation ofactivation of bed alarm as identified in the Fall Risk assessment. The Chief Clinical Officer or Designee will review theresults of the weekly audits with the House Supervisors. The Chief Clinical Officer and the HouseSupervisors will develop a corrective action plan for non-compliantemployees (to be initiated by 6/7/16). The Chief Clinical Officer will report audit results to theQuality Assurance Performance Improvement and Medical Executive Committeesmonthly. The Chief Clinical Officer willcontinue auditing per the recommendation of the Quality Assurance, PerformanceImprovement Committee (to be completed by 7/7/16). The Director of Quality will report the audit results to theGoverning Board quarterly via the central secured repository, Governing BoardCentral (to be completed by 7/7/16). To prevent reoccurrence of the deficiencies, the ChiefClinical Officer or Designee will continue the random audit quarterly. The Chief Clinical Officer will present theaudit results along with the corrective action implemented	

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	chair alarms were considered for use. D. Patient #p9 medical record's Nursing Shift assessment - Flowsheet Detail, dated 4/7/2016, indicated Morse Fall Risk Score totaled 75.0. The medical record lacked documentation that bed and chair alarms were considered for use. 4. Patient #p9 had an incident dated and time of 2/14/2016 at 10:00 PM. The incident report indicated the patient discovered date was on 2/15/2016 at 10:00 PM. The report indicated, "The patient was found on the floor by the nurse." The incident report noted the fall prevention interventions prior to the fall were: frequent visual checks, and call bell in reach. The incident report did not indicate the bed alarm was engaged for patient #p9 that had a fall precaution of high risk. 5. Patient #p9 had a second incident dated and time of 3/12/2016 at 4:30 AM. The incident report indicated, "At 0443 the assigned nurse reported that the patient was found on the floor by another nurse. The nurse stated she did not activate the bed alarm." The incident report noted the fall prevention interventions prior to the fall were: frequent visual checks, call bell in reach, personal items in reach, verbal reminders,		(aggregate) to theQuality Assurance, Performance Improvement and Medical Executive Committeesquarterly, and to the Governing Board quarterly via the central securedrepository, Governing Board Central for review. The Chief Clinical Officer will continue auditing per the recommendationof the Quality Assurance, Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152028	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/07/2016
NAME OF PROVIDER OR SUPPLIER VIBRA HOSPITAL OF NORTHWESTERN INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 9509 GEORGIA ST CROWN POINT, IN 46307	

(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
	ID'd as fall risk, light on in room, and low bed. The incident report did not indicate the bed alarm was engaged for patient #p9 that had a High Risk fall precaution. 6. At 1:40 PM on 4/7/2016, #p6 and #p9's rooms were observed with staff members #3 (CCO), #6 (RN Supervisor) and #5 (Plant Operations). #p6 and #p9's beds were observed with bed alarms that were not on. 7. At 2:45 PM on 4/7/2016, staff member #1 (Director of Quality) indicated all patients of the hospital are assessed as universal fall precaution at a minimum; however, High Risk fall precaution shall be initiated when the assessment requires it.			