STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151311	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH TIPTON HOSPITAL INC	1000 S MAIN ST TIPTON, IN 46072

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S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 5/18/2015 through 5/20/2015 Facility Number: 005049 QA: cjl 06/05/15	S 0000		
S 0178 Bldg. 00	410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a) (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system. Based on observation and staff interview, the hospital failed to ensure the hospital license was conspicuously posted for patient viewing at Indiana University	S 0178	1. To correct the lack of posting the license conspicuously, IU Health Tipton Hospital's license was moved from a hallway near the north entrance to the main lobby near the south entrance of the building. The Coordinator of Quality/Risk	05/20/2015

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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	Health Tipton Hospital. Findings included: 1. At 12:15 PM on 5/19/2015, Indiana University Health Tipton Hospital was observed without a copy of the Indiana State Hospital License posted at the entrance or in the lobby of the building for the patients and visitors to view. The Indiana State Hospital License was posted at the employee entrance located at the rear of the hospital. 2. At 2:00 PM on 5/19/2015, staff member #7 (physical plant supervisor) indicated the hospital main entrance used to be located in the rear of hospital until the new main entrance was opened. The staff member confirmed the Indiana State Hospital License was not conspicuously posted for patient viewing when entering the hospital.		Management/Infection Prevention will be ultimately responsible.	

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S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 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, the facility failed to ensure 6 contracted services and 2 non-contracted services as part of its comprehensive quality assessment and improvement (QA&I) program. Findings included: 1. The 2015 Quality Assessment and Performance Improvement indicated all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.	S 0406	2. To be in compliance with a hospital-wide Quality assessment program that all areas participate in, with responsiblity falling to the Director of Risk Management and Corporate Compliance, the following services with direct or indirect impact on patient care were added to the departmental Quality reports collected. An inventory of reporting departments and leaders responsible for submission will be created by the Quality Coordinator to facilitate tracking receipt of reports. Lab--the PI report for 2nd quarter 2014 was added to the reports from other quarters that were already in the binder reviewed by the surveyor. This dashboard includes the measures of ED turn-around times, OP	07/01/2015

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	2. Review of the facility's Performance Improvement Plan indicated it did not include contracted services: laboratory, blood bank, laundry, speech pathology, biohazard waste hauler, and teleradiology. The following non-contracted services were not evaluated through the comprehensive quality assessment and improvement program: laundry and pediatrics. 3. At 1:45 PM on 5/18/2015, staff member #2 (CNO) confirmed contracted services: Biohazard laboratory, blood bank, laundry, speech pathology, biohazard waste hauler, teleradiology; and laundry, pediatrics non-contracted services were not part of the hospital's comprehensive quality assessment and improvement program.		ordered vs. reported accuracy, communication of corrected results and use of 2 patient identifiers.Blood bank--the Lab department had blood transfusion Quality management reports; however, that data was not being shared with the Quality department. Blood transfusion reports for the most recent 5 quarters are now on file in the Quality department PI report binders. This report includes data on cross matching, apheresis, components wasted and transfusion reactions. To ensure this report is shared quarterly, leaders at multiple levels (Coordinator, Manager, Vice President) are now aware of the need. 6/23/15 CompletedLaundry--all contracted and non-contracted services will be evaluated and included in Facilities' performance improvement plan starting with the current quarter. starting 2nd quarter 2015 (6/30/15)Speech pathology--beginning with the next quarter, 10% of patient charts who have barium swallow tests will be audited monthly. The goal will be for 90% of these patients to reach their improvement goal as assessed by the therapist. starting 3rd quarter 2015 (7/1/15)Biohazard waste hauler--all contracted and non-contracted services will be evaluated and included in Facilities' performance improvement plan starting with	

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			the current quarter. starting 2nd quarter 2015 (6/30/15)Teleradiology--The Site Supervisor of Health Information Management Operations confirmed that all but 2 of IU Health Tipton's credentialed radiologists do remote reading exclusively, and the 2 radiologists who do come on site sometimes read remotely. This essentially makes all radiologists at IU Health Tipton teleradiologists. Performance improvement data is reported by the radiology practice group to Medical Staff Services. This data is used for Joint Commission accreditation's Ongoing Professional Practice Evaluation and credentialing. Quality Improvement data reports for the most recent 4 quarters were included in the binders of reports shown to the surveyor in May, although it was titled "imaging" and not specifically as "teleradiology." Measures reported include radiology peer review and turn-around time in minutes from order to completion. 5/20/15 CompletedPediatrics--a Quality Improvement Plan for pediatrics was developed by the Director of Acute Care Services and the Coordinator of Med/Surg & ICU, and was added to that department's existing performance improvement plan. The process of obtaining and documenting admission weights of pediatric patients in the Electronic Health Record was	

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			selected with a target of 100% accuracy. 6/18/15 Completed	
S 0554 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on document review, observation and interview, the facility failed to provide an environment that minimizes the risk of infection exposure. Findings: 1. The policy/procedure titled Cleaning and Disinfection Guidelines, IC-104, last reviewed 7/8/2014, Section V., indicates: B. Handle all soiled equipment so as to not contaminate self or the environment. F. The soiled utility room may be used for storage of items that have been cleaned but not disinfected. 2. While touring the surgery department on 5/19/2015 at 0900 hours, the following observations were made: a. The Neptune surgical suction device was stored in the soiled utility room. It was uncovered and the output suction hose was stored in the water in	S 0554	To ensure that the risk of infection exposure is minimized, the following corrections were made:2a. Install air gap on output of the Neptune suction hose to ensure the hose can be safely stored outside of water. Ongoing rounding by OR management will make sure this practice change is being enforced and hardwired. The Director of Surgery is ultimately responsible for seeing that this is completed. 6/28/15 Will be completed2b. Correct storage practices for boxes will be strictly enforced (storage off of floor, no corrugated boxes in surgery area). Daily rounding within the department by OR management will be done to make sure that storage practices are being enforced. The Director of Surgery will be responsible. 5/22/15 Completed4a. A color picture was laminated and hung above the endoscope hopper regarding the proper placement of the hose after use. Staff was educated on the proper way to hang the hose after usage and	06/28/2015

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	the hopper, allowing the risk of bacteria to migrate up into the equipment. b. In the orthopedic supply room, a dusty box of positioning devices was stored on the floor. 3. The policy/procedure Cleaning, Disinfecting, and Sterilization of Flexible Endoscopes, IP-2, approved 2012, indicates in section V: G. All staff in any setting where endoscopy procedures are performed must adhere to infection control principles that will maintain a safe environment, free from the possibility of spreading disease to patients and co-workers. U. Endoscopes should be stored in a manner that will protect the endoscopes and minimize the potential for residual moisture. 4. It was observed on 5/19/2015 at 0945 hours: a. In the dirty endoscope room, the end of a hose from the faucet of a hopper was stored in the water risking contaminants migrating back into the clean hose. b. In the clean endoscope room, an endoscope was hanging with the end touching a chux, inhibiting air drying and risking bacteria from the scope drainage migrating up into the scope.		this will be reinforced at staff meetings. OR management will do ongoing rounding to make sure the practice change is being enforced and hardwired. The Director of Surgery is ultimately responsible. 5/22/15 Completed4b. Chux will be folded to fit properly and decrease the flipping up of edges, eliminating the potential for scopes to touch edges of the chux and decreasing potential risk of infection. Staff was educated and information was reinforced at a meeting. Ongoing rounding by OR management will be done to make sure the practice change is being enforced and hardwired. The Director of Surgery is ultimately responsible. 5/22/15 Completed	

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	5. During an interview on 5/19/2015 at 1000 hours, staff member #2, Chief Nursing Officer, confirmed the above findings.			
S 1118 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on document review, observation, and staff interview, the hospital failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in three (3) instances.	S 1118	3, 4 & 5. To meet OSHA standards assuring the safety and well-being of patients, visitors and staff, eyewash stations will be added in the boiler room, environmental storage room in the lower level and the laundry soiled room. The Director of Operations is ultimately responsible.	07/08/2015

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	Findings included: 1. Indiana University Health Tipton Hospital Safety Plan (last revised 2/2015) indicated the the hospital-wide safety program shall comply with OSHA requirements. 2. OSHA considers the guidelines set by such sources as American National Standards Institute (ANSI) proper maintenance and weekly testing is necessary to ensure that Emergency Drench Showers and Eyewash Stations are functioning safely and properly. Weekly testing helps clear the supply lines of sediment and bacteria build-up that is caused from stagnant water. The ANSI standard states that plumbed flushing equipment, "shall be activated weekly for a period long enough to verify operation and ensure that flushing fluid is available". Furthermore, the ANSI Z358.1-2009 standard also requires Portable and Self Contained			

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	equipment be visually checked to determine if flushing fluid needs to be changed or supplemented. The eyewash station and or shower combo has to be easily accessible at all times. 3. At 2:30 PM on 5/19/2015, the boiler room was toured. Water testing was conducted in this department which includes acid, buffer solution and other chemicals. The assorted toxic chemicals' manufacturer label specified that 15 minutes of flushing of eyes was needed if the chemical comes into contact with a person's eyes. The department did not have an eye wash station that meets the needs of the chemicals that are being used. 4. At 2:45 PM on 5/19/2015, the environmental storage room was toured. The room contained 12-volt battery operated floor scrubbers. During the inspection, one floor scrubber was observed connected to a 12-volt charger with			

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	the batteries exposed during the charging of the equipment. The room was observed with a 20-ounce bottle of saline solution for flushing of eyes; however, the 20-ounce bottle will only provide 2 to 3 minutes of flushing. The battery acid requires an emergency eye wash station that provides 15 to 20 minutes of flushing of eyes. Therefore, the room did not have a proper eye wash station accessible to personnel when needed. 5. At 2:55 PM on 5/19/2015, the soiled room where the commercial washing machines were located was toured. The laundry room has assorted bulk chemicals for the washing machines and the chemicals manufacturer label specified that 15 minutes of flushing of eyes was needed if the chemical comes into contact with a person's eyes. However, there was a 20-ounce bottle of saline solution mounted on the wall. The bottle of saline solution will only provide 2 to 3 minutes of flushing of eyes			

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	when needed for an emergency. Therefore, the room did not have a proper eye wash station accessible to personnel when needed. 6. At 3:00 PM on 5/19/2015, staff member #7 (Physical Plant Supervisor) confirmed the boiler room, environmental storage room, and the commercial washing machine soiled utility room did not have the proper eye wash station available to meet the first aid requirements on the chemicals' manufacturer labels.			
S 1164 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:			

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	(B) There shall be evidence of preventive maintenance on all equipment. Based on document review and staff interview, the facility failed to assure preventive maintenance was conducted on the In-patient Rehabilitation wooden steps. Findings included: 1. Indiana University Health Tipton Hospital Medical Equipment Management Plan (last March 2014) states, "Medical Equipment- Fixed and portable equipment used for diagnosis, treatment, monitoring, and direct care of individuals. The Clinical Engineering Associates manage the schedule and timely completion of the calibration, inspection, and maintenance activities required for for safe, reliable performance of medical equipment." 2. Review of facility documents on preventive maintenance of patient care equipment indicated the hospital lacked evidence of	S 1164	2. To achieve compliance with the requirement for evidence of preventative maintenance on all equipment, the wooden steps used by Rehabilitation inpatients was added as an asset to IU Health Tipton's inventory and proper maintenance procedures were implemented. The Director of Operations is ultimately responsible.	05/22/2015

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	preventive maintenance was on the In-patient Rehabilitation wooden steps. 3. At 3:00 PM on 5/19/2015, staff member #20 (Biomedical Engineer) confirmed the In-patient Rehabilitation wooden steps was not on a preventive maintenance schedule and has never had a preventive maintenance inspection conducted on it.			