STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED CARING CENTER OF MEMORIAL HOSPITAL	800 W NINTH ST JASPER, IN 47546

(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
F 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey Survey dates: March 23, 24, 25, 26 and 27, 2015 Facility number: 000202 Provider number: 155305 AIM number: 100284870 Survey team: Dorothy Watts, RN-TC (3/23, 3/24, 3/26, 3/27/15) Sylvia Scales, RN Census bed type: SNF/NF: 15 Total: 15 Census payor type: Medicare: 14 Other: 1 Total: 15 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1 Skilled Caring Center of Memorial Hospital was found to be in compliance	F 000		

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.

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
	155305		03/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED CARING CENTER OF MEMORIAL HOSPITAL	800 W NINTH ST JASPER, IN 47546

(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
	with 42 CFR part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Recertification and State Licensure Survey. Quality review completed on April 1, 2015 by Jodi Meyer, RN			
F 999 Bldg. 00	Personnel 3.1-14 (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The results shall be recorded in millimeters of induration with the date given, date read, and by whom. The tuberculin skin test must be read prior to the employee starting to work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment and at least annually	F 999	**Credible Allegation of Compliance and Correction:** Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation or State findings, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Four employees did not have a 2-step PPD skin test	04/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER SKILLED CARING CENTER OF MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 800 W NINTH ST JASPER, IN 47546	

(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
	thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second step test should be performed (1) to three (3) weeks after the first step. The frequency of repeat testing depends on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure new employees received their tuberculin skin testing (PPD) using the Mantoux method and/or received a chest x-ray prior to the employees starting work. (Employee #1, Employee #2, Employee #3, employee #4) Findings include: The employee health files were reviewed		or chest x-ray completed upon hire. However, the employees did have the QuantiFERON-TB Gold (T-Spot.TB) test upon each employees hire date. All four employees test results were Negative for TB. **Exhibit A** –The four employees QuantiFERON-TB Gold (T-Spot.TB) test results. 03/09/15 Prior to the surveyors arriving to conduct our annual survey, when auditing the new hires records from 2014-current, the DON found the employees did not have a two-step PPD skin test upon hire or a current chest x-ray. The DON contacted the employees and a first step PPD test was initiated as soon as each employee could get it completed. There are a total of five employees who the DON found that had only received the QuantiFERON-TB Gold (T-Spot.TB test) upon hire. 04/13/15 Employee #1, #2, #3 have completed the 2-step PPD skin test. Employee #4, who is a known reactor, completed a Chest x-ray on 06/06/12 and completed an assessment sheet in July, 2014 and again on 03/22/2015. The other employee has completed the first step PPD skin test and will be completing the second step PPD skin test in the time frame required. **Exhibit B-**Documentation of TB screening assessment for the four employees. The practice for Memorial Hospital and Health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER SKILLED CARING CENTER OF MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 800 W NINTH ST JASPER, IN 47546	

(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
	on 3/27/15 at 9:00 A.M. and documented the following: 1. Employee #1's start date was documented as 3/4/14, but received the first PPD skin test (Mantoux) on 7/11/14. 2. Employee #2's start date for employment was documented as 1/27/14. Employee #2 received the first PPD skin test (Mantoux) on 7/17/14. 3. Employee #3's start date for employment was documented as 10/13/14. Employee #3 had not received the first PPD skin test (Mantoux) as of 3/27/15. 4. Employee #4's start date for employment was documented as 4/14/14. Employee #4 was a previous positive reactor to the Mantoux skin test, but did not receive a chest x-ray prior to employment. During an interview on 3/27/15 at 9:38 A.M., the Infection Control Nurse (INFCN) indicated it was the facility's policy to ensure employees had a 2 step Mantoux skin test and/or a chest x-ray before starting work. The IFCN further indicated a few employees' Mantoux test were missed when they were hired.		Care Center - Acute Care has been the use of the QuantiFERON-TB Gold (T-Spot.TB) test upon hire as an acceptable practice as a TB screening tool for new hires since 2012 and has been recognized as an acceptable method by ISDH-Acute Care Division as recommended by the CDC guidelines. **Exhibit C-Guidelines for using the QuantiFERON-TB Gold Test for Detecting Mycobacterium tuberculosis Infection**. **Exhibit D- Clinician Review on TB screening.** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** 04/13/15 Employee #1, #2, #3 have completed the 2-step PPD skin test. Employee #4, who is a known reactor, completed a chest x-ray on 06/06/12 and completed an assessment sheet in July, 2014 and again on 03/22/2015. The other employee has completed the first step PPD skin test and will be completing the second step PPD skin test. **Exhibit B-**Documentation of TB screening assessment for the four employees. 04/13/15 The Healthcare Personnel Immunization Record which is utilized for each new employee was revised. Under the Tuberculosis Screening section an asterisk and in bold letters the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER SKILLED CARING CENTER OF MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 800 W NINTH ST JASPER, IN 47546	

(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
	During an interview 3/27/15 at 9:38 A.M., the ADON (Assistant Director of Nursing) indicated a problem with administering the 2 step test had been identified and that steps were being taken to correct the problem. The Policy and Procedure for "Employee Health/Respiratory Program/Exposure Prophylaxis" provided by the Director of Nursing on 3/27/15 at 11:13 A.M. indicated, "...A 2-step PPD skin test for all new hires...Chest X-ray...(when physician requests it or the individual has a positive PPD skin test..."		following statement was inserted "2 STEP PPDS ARE REQUIRED FOR SKILLED, IRC, HOME CARE, AND PALLIATIVE CARE". 04/13/15 Employee Health staff changed their process to include a double check on each new employee health record for Skilled Caring Center. **Exhibit E – Updated Healthcare Personnel Immunization Record.** ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;*** 04/13/15 The Healthcare Personnel Immunization Record which is utilized for each new employee was revised. Under the Tuberculosis Screening section an asterisk and in bold letters the following statement was inserted "2 STEP PPDS ARE REQUIRED FOR SKILLED, IRC, HOME CARE, AND PALLIATIVE CARE". 04/13/15 Employee Health staff changed their process to include a double check of each new employee health record for Skilled Caring Center. **Exhibit E – Updated Healthcare Personnel Immunization Record.** ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** 04/13/15 The Healthcare Personnel Immunization Record which is utilized for each new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILLED CARING CENTER OF MEMORIAL HOSPITAL	800 W NINTH ST JASPER, IN 47546

(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
			employee was revised. Under the Tuberculosis Screening section an asterisk and in bold letters the following statement was inserted “2 STEP PPDS ARE REQUIRED FOR SKILLED, IRC, HOME CARE, AND PALLIATIVE CARE”. 04/13/15 Employee Health staff changed their process to include a double check of each new employee health record for Skilled Caring Center. **Exhibit E – Updated Healthcare Personnel Immunization Record.** ***Date of Completion:*** 04/13/15	