

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2012
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A. PROVIDER OR SUPPLIER ROCKWOOD SOUTH HILL	STREET ADDRESS, CITY, STATE, ZIP CODE EAST 2903 25TH AVENUE SPOKANE, WA 99223
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Rockwood South Hill on 8/23/12, 8/24/12, 8/27/12, 8/28/12, and 8/29/12. A sample of 30 residents was selected from a census of 32. The sample included 26 current residents and the records of 4 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Linda Loffredo, R.N., B.S.N. Rose Miller, R.N., B.S.N. Sandra Lindgren-Smith, M.S.W.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Adult Services Administration Residential Care Services, District 1B Rock Pointe Tower 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7303 Fax: (509) 329 3993</p> <p><i>Sandra J. Hansen RN MD</i> Residential Care Services Date 9/7/2012</p>	F 000	<p>Please refer to the attached Plan of Correction (POC)</p> <p style="text-align: center;">RECEIVED OCT 01 2012 DSHS ADJA RCS SPOKANE WA</p>	9/28/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO/Administrator	(X6) DATE 9/28/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards 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 participation.

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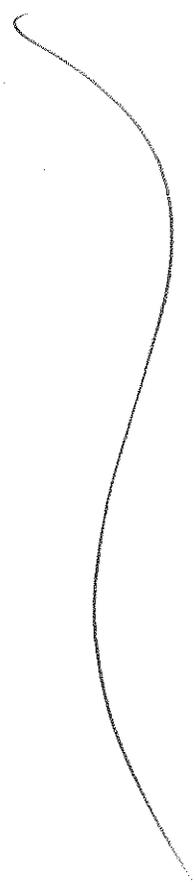
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F 309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide necessary care and services related to bowel management and skin conditions for 2 of 11 residents in a sample of 30 (#2,14). Resident #14 experienced harm related to the facility's failure to re-evaluate the ongoing symptoms of constipation resulting in the repeated episodes of manual removal of fecal material (an invasive procedure).</p> <p>Findings include:</p> <p>Resident #14 per record review had a history of constipation, required total assistance with toileting and was occasionally incontinent of bowel. The resident experienced a significant weight loss since admission (██████) including a loss of appetite and poor fluid intake.</p> <p>According to the medication record she received a stool softener and a stimulant laxative twice daily for bowel management. The resident had as needed medications for constipation including lax loaf, Milk of Magnesia (MOM) if no bowel movement (BM) in 2 days, a Dulcolax</p>	F 309	<p>Refer to Attached POC</p> 	

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F 309	<p>Continued From page 2</p> <p>suppository if no BM in 3 days, and an enema on day shift the 3rd day of no BM.</p> <p>Per review of the August 2012 bowel record, the resident had no BM on 8/12, 13/12 and received a dose of as needed lax loaf.</p> <p>On 8/13/12 at 2:00 p.m. a licensed nurse documented the resident had a hard time eliminating stool. She identified the resident had hard stool present in her rectal vault and the nurse digitally removed some stool. The resident was able to eliminate a small amount of stool after the digital removal. The nurse documented the resident was to receive MOM from the evening nurse and the day nurse gave lax loaf. According to the note, the resident complained of stomach pain following lunch. There was no evaluation of the resident's bowel/abdominal status at that time.</p> <p>At 4:00 p.m. on the same day a nurse documented the resident's rectal vault contained firm hard stool. The resident initially refused the suppository, but later accepted the medication. The note indicated the resident had no results from the suppository at the time the note was written and the oncoming nurse would be notified of the resident's bowel status.</p> <p>On 8/14/12 at 12:00 p.m., a nurse documented the resident had difficulty eliminating stool on her own over the past 2 weeks. The licensed nurse digitally removed some firm hard stool just before lunch and the physician was notified.</p> <p>At 2:00 p.m. on the same day a nurse documented that before lunch the resident needed assistance with eliminating a small amount of hard stool, the resident stated "I can't do it, I need help". The note indicated the resident was fidgety and uncomfortable until the</p>	F 309	<p>Refer to attached POC</p> 	



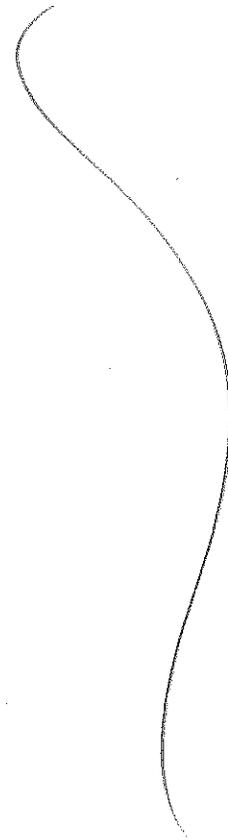
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F 309	<p>Continued From page 3</p> <p>stool was digitally removed. According to the bowel record, the resident had a medium size BM. The resident refused her evening dose of stool softener. A bowel/abdominal evaluation was not conducted and no further as needed bowel medications were implemented.</p> <p>The bowel record indicated the resident had a small BM on 8/15 and 16/12.</p> <p>A fax was sent to the physician on 8/16/12 regarding the need to digitally remove firm to hard stool over the past 2 weeks. The note indicated the routine bowel medications were not effective. The physician ordered the stimulant laxative dose to be doubled.</p> <p>The medication log indicated that on 8/16/12 at 7:30 p.m. the resident refused her evening and bedtime medications due to abdominal discomfort.</p> <p>According to the bowel record, the resident had a small BM on 8/17/12 and 2 smalls on 8/18/12.</p> <p>On 8/18/12 at 2:00 p.m. a nurse documented the resident was restless and was placed on the commode. The resident was unable to eliminate any stool and the nurse offered to help remove the stool, but the resident declined the help. Per the same note, the resident was placed on the commode a second time and requested help from the nurse. The licensed nurse removed 3 firm/dry sections of stool. According to the note, the increase in the stimulant laxative had not improved the resident's constipation. The resident was given the as needed lax loaf, but there was no further evaluation of her bowel/abdominal status.</p> <p>Per the medication log on the same day, during evening shift, the resident received as needed MOM for no BM. A 10:15 p.m. progress</p>	F 309	<p>Refer to attached POC</p> 	
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F 309	<p>Continued From page 4</p> <p>note indicated the resident had not had a BM following the MOM.</p> <p>The physician visited the resident on 8/19/12 and ordered a fiber type laxative for the resident. A 2:40 p.m. progress note identified the resident was uncomfortable while sitting in a chair due to her bowel problems. At 10:00 p.m. a nurse documented the resident had trouble passing BM and the nurse had to digitally remove stool. According to the note, the resident said "I feel so much better now". There was no evaluation of the resident's bowel/abdominal status, nor were other as needed bowel medications implemented.</p> <p>According to the bowel record, the resident had 2 small BM's on 8/19/12 and 1 small on 8/20/12.</p> <p>On 8/20/12 at 2:00 p.m. a nurse documented the fiber laxative was started that morning and the resident's bowels should be monitored over the next few days. According to the note, the resident had a small stool, but could not completely eliminate it on her own. She tried to push the stool out, the stool was visible, so the nurse helped digitally remove the stool. The nurse described the stool as firm and dry. A 6:00 p.m. note indicated the resident had not had a BM. The resident's bowel/abdominal status was not evaluated, nor were other as needed laxative medications implemented.</p> <p>On 8/21/12 at 3:00 a.m., a licensed nurse documented the resident did not have adverse side effects from the fiber laxative and she had not complained of inability to pass stool. At 2:00 p.m., a note indicated the resident was able to eliminate a small BM on her own. The physician was updated on the resident's bowel status.</p> <p>The medication log indicated the resident received the as needed lax loaf on 8/20 and</p>	F 309	<p>Refer to attached POC</p> 		

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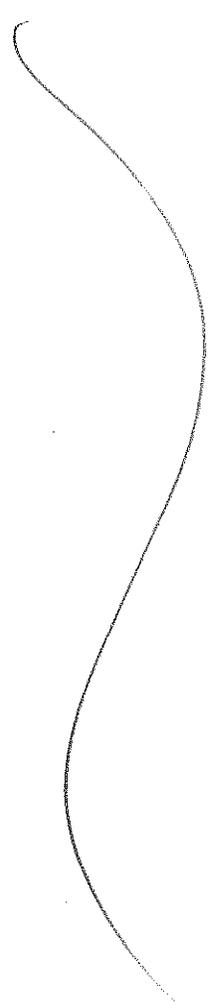
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F 309	<p>Continued From page 5</p> <p>21/12. The bowel record identified the resident had 2 small BM's on 8/21/12 and 2 on 8/22/12.</p> <p>According to the medication log/bowel record, the resident received MOM on 8/23/12 for no BM in 2 days. On 8/24/12 at 1:45 a.m., the resident received a suppository for no BM in 3 days. The record indicated the resident had an extra-extra large BM on night shift and an extra large BM on evening shift. The as needed medications were helpful in promoting a BM for the resident.</p> <p>Social services staff visited with the resident on 8/24/12. According to the note, the resident visited about her feelings and concerns. The staff documented the resident was "fixated" on her constipation concerns and reported to them that she was not interested much in eating because of her constipation.</p> <p>According to the facility's January 2012 Bowel Assessment Policy and Procedure, bowel records were to be checked every shift. The resident's frequency of stool, characteristics of stool, recent bowel changes, use of laxatives, dietary intake and drinking habits were to be assessed. Visual inspection of the abdomen should occur, looking for; symmetry, masses, protrusion and movement. The abdomen was to be palpated for distension, softness/firmness, and the bowel tones were to be listened to by the nurse. The physician was to be notified of the assessment and nursing interventions were to be initiated as needed.</p> <p>Staff #A was interviewed on 8/29/12 and was unable to provide further information related to bowel assessments or other interventions for the resident during the time frame.</p> <p>The resident had documented incidents of discomfort, lack of appetite, decreased fluid intake and weight loss. She experienced ongoing</p>	F 309	<p>Refer to Attached POC</p> 	

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F 309	<p>Continued From page 6</p> <p>constipation which required digital removal of hard/firm stool. The resident's bowel/abdominal status was not assessed, nor were the as needed laxative medications consistently used to promote regularity or comfort.</p> <p>2. Resident #2 had diagnoses including stroke and memory loss. Per record review, the resident had memory problems, no mood/behavior problems, required extensive to total assistance with activities of daily living, and had persistent skin problems due to moisture on her coccyx and buttocks.</p> <p>Review of the April 2012 Treatment Record (TAR) revealed the resident had an area on the right buttock that was about 0.5 centimeters (cm) in size with no additional description except that it was healing.</p> <p>There was no information about a right buttock skin problem in May 2012 TAR.</p> <p>Review of a nursing note on the June 2012 TAR dated 6/5/12 noted an open area on the right buttock about 1.5x1.5 cm with 0.1 depth. The dressing was changed on that date with no additional information about what the dressing treatment was or how often it was changed.</p> <p>Review of the July 2012 TAR revealed nursing notes on 5 days during the month. The nursing notes dated 7/27/12 and 7/28/12 noted the skin area was 1x1 cm and the treatment was on hold waiting for a clarification order from the physician.</p> <p>Per record review, on 7/31/12 the physician ordered a new right buttock treatment including applying a foam dressing every 3 days or as needed until healed.</p> <p>Review of the August 2012 TAR revealed the treatment was done every 3 days and was last done 8/25/12. There was no evaluation of the</p>	F 309	<p>Refer to attached POC.</p> 

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F 309	Continued From page 7 effectiveness of the skin treatment including measurements or description of the skin problem. During observation of care on 8/28/12 at 1:05 p.m. with Staff #F and #G, there was no dressing on the right buttock. There was a small red area on the right buttock with mostly intact skin and a pinpoint scab near the right margin. Staff #F stated the foam dressing gets soiled during toileting and Staff #G stated the evening shift licensed nurses applied the skin treatments. At the completion of care, Staff #F did not notify the licensed nurse of the lack of dressing to the right buttock. In an interview on 8/28/12 at 2:55 p.m., Staff #C stated the evening shift licensed nurses did the treatments. She stated between dressing changes she checked the dressing if she was notified it needed to be changed. She confirmed the dressing on the right buttock should be in place all the time. The surveyor informed her the dressing was not in place at 1:05 p.m. and she stated she was not notified by the nursing assistants. On 8/28/12 at 3:00 p.m. the resident's clinical record was reviewed with Staff #A. Staff #A stated she had no additional information to offer regarding the right buttock skin problem. She confirmed the licensed nurses should monitor each skin problem daily and document the daily evaluation on the TAR until each area was resolved.	F 309	Refer to Attached POC		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329			

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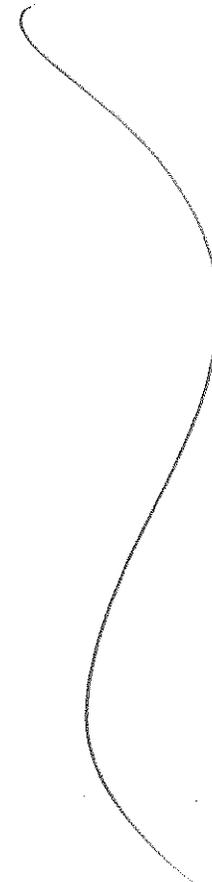
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F 329	<p>Continued From page 8</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure 1 of 10 residents reviewed for unnecessary medications (#9) in a sample of 30 received adequate monitoring for effectiveness of psychoactive medications.</p> <p>Resident #9 had diagnoses including heart problems and dementia. Per the most recent assessment, the resident had memory problems, no persistent mood or behavior problems, and required extensive assistance with most activities of daily living. The resident had a physician order for a low</p>	F 329	<p>Refer to Attached POC</p> 	

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F 329	<p>Continued From page 9</p> <p>dose of antidepressant medication for symptoms of agitation and depression.</p> <p>Per record review, the resident had some episodic behaviors of isolation, refusing care, and yelling. The resident's care plan directed staff to accommodate her needs as much as possible and/or provide redirection.</p> <p>Per record review, the resident had documented episodes of agitation and yelling on 7/28/12 and 8/20/12.</p> <p>On 8/20/12 a licensed nurse contacted the physician with a report that the resident was having mood swings, agitation, and was resistive to care. An increase in the antidepressant medication was requested and approved by the physician.</p> <p>Per record review, there was no referral to social services to evaluate the frequency of the resident's behavior and the effectiveness of the current interventions. There was no behavior monitor initiated to evaluate the effectiveness of the current interventions and medication effectiveness.</p> <p>On 8/24/12 at 9:50 a.m., the resident was in the sunroom singing quietly and counting birds. Later in the morning she was moving through the halls in her wheelchair singing quietly to herself.</p> <p>In an interview on 8/29/12, Staff #B stated the resident's target behavior was more agitation than anxiety which was usually not a persistent symptom. She stated the request for a medication increase should have been reviewed with a behavior committee staff member prior to sending the request to the physician. She confirmed a behavior monitor should have been started when medication dosage was increased.</p>	F 329	<p>Refer to attached POC</p> 	
F 332 SS=E	483 25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	<p>Continued From page 10</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain a medication error rate less than 5% for 3 of 12 (#6,17,42) residents observed during medication pass in a sample of 30. The medication error rate was 10%.</p> <p>(Refer to F333 for details related to a significant medication error for Resident #17.) Findings include:</p> <p>1. On 8/28/12 at 7:30 a.m., Staff #D was observed to and administer several medications to Resident #6. The medications included; a calcium supplement and an iron supplement. Staff #D prepared and administered a calcium supplement 500 mg that contained vitamin D 400 iu. According to the medication log, the resident was to receive calcium ergocalciferol 500 mg. The nurse was interviewed regarding the variance and stated the medications were the same. Staff #A was interviewed at 3:15 p.m. and verified the medications were different per the pharmacy. She verified a medication error occurred. Staff #D prepared and administered 324 mg of iron. The physician's order identified the resident was to receive 325 mg of iron. The nurse was interviewed and said the medications were similar and she gave what pharmacy sent. The dosage</p>	F 332	Refer to attached POC	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2012
NAME OF PROVIDER OR SUPPLIER ROCKWOOD SOUTH HILL		STREET ADDRESS CITY, STATE, ZIP CODE EAST 2903 25TH AVENUE SPOKANE, WA 99223		
(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 332	Continued From page 11 was not accurate, which constituted a medication error. Further review of the medication log indicated the resident had a weekly dose of Alendronate (a medication used to treat osteoporosis) scheduled to be given on 8/27/12. The medication was not initialed as given on that day. Staff #D was interviewed at the time, she checked the bubble pack of medication and verified the medication was not given as scheduled. 2. Staff #D prepared and administered medications to Resident #42 on 8/28/12 at 8:35 a.m. The nurse gave a multivitamin with iron. According to the physician's orders, the resident was to receive a multivitamin with minerals. The nurse was interviewed and stated the vitamins were the same. Staff #A was interviewed at 10:00 a.m. and said the pharmacy had labeled the packaged vitamin inaccurately. She did verify a medication error occurred due to the nurse giving the medication without verification of the accuracy.	F 332	Refer to Attached POC	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure 1 of 12 residents observed during medication pass (#17) in a sample of 30 was administered the correct dose of insulin. This medication error placed the resident at risk for	F 333		

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F 333	Continued From page 12 fluctuations in blood glucose control and constituted one significant medication error. (Refer to F332 for Medication Error Rate.) Findings include: Resident #17 had diagnoses including diabetes. The resident had physician orders for twice daily blood glucose monitoring and short-acting insulin to be administered per sliding scale dosage based on the blood glucose results. During observation of medication pass on 8/27/12 at 4:00 p.m., Staff #E checked the resident's blood glucose and obtained a result of 149. Staff #E reconciled the blood glucose result with the sliding scale insulin orders and stated the resident required 2 units of short-acting insulin. She drew up 3 units of insulin and prepared to administer the insulin to the resident. At the doorway of the resident's room the surveyor requested Staff #E to recheck the resident's physician orders. Staff #E confirmed the resident should have 2 units administered. She then prepared and administered 2 units of short-acting insulin. The failure to ensure the resident would receive the correct dose of insulin constituted one significant medication error.	F 333	Refer to attached POC		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431			

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F 431	<p>Continued From page 13 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure medications were consistently locked in 1 of 2 medication carts when unattended by licensed nurses. Failure to consistently secure medications placed residents at risk for obtaining potentially harmful medications.</p> <p>Findings include:</p>	F 431	<p>Refer to attached POC</p> 	

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F 431	Continued From page 14 On 8/23/12 at 10:20 am the medication cart was in the front hall, was unlocked and not within sight of a licensed nurse. The drawers were opened and the cart contained several medications and treatments. Staff members, residents, and visitors walked by the cart. Staff #1 came out of the nurses' station at 10:30 a.m. and verified the cart should have been locked when she left it. Medication carts are to be locked and/or in full view of the licensed nurse in order to be considered secure from possible misuse or accidental ingestion by residents.	F 431	Refer to attached POC		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441			

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F 441	<p>Continued From page 15</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the proper infection control practices for positive staff TB testing were followed for 1 of 5 staff reviewed (#H).</p> <p>Findings include:</p> <p>Staff files were reviewed on 8/29/12. Staff #H was hired 8/8/12 and her first step TB test identified results of 5 mm. A second step TB test was conducted on 8/10/12 with the results in 10 mm. The record contained no evaluation or further follow-up with the staff member regarding the results of the TB test.</p> <p>Staff #A was interviewed and referred to the Center for Disease Control (CDC) for evaluating the results. The CDC information considered a 10 mm result as positive if the individual met certain criteria including; foreign born or employees of high-risk congregate settings (long</p>	F 441	<p>Refer to Attached POC</p> 

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F 441	Continued From page 16 term care facilities). The facility did not take appropriate action to evaluate or intervene with a positive TB test of an employee, including; evaluation of the risk factors, signs of symptoms of TB, and/or chest x-ray to rule out active TB. Staff #A stated Staff #H worked routinely with the residents.	F 441	Refer to Attached POC	

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