PRINTED: 02/25/2011
FORM APPROVED

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0003	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE (	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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) COMPLETE DATE
SNH	LIC REGS FOR NURSING HOMES This State Rules and Regulations is not met as evidenced by: STATE STANDARD Rules and Regulations for Program Administration of Nursing Care Facilities. Chapter 11. Section 5. Organization and Administration. (b)(iv)(A) Tuberculin testing shall be accomplished for each employee and before resident contact begins and annually thereafter. (b)(iv)(D) Individuals never having had a skin test or who do not have written proof of skin test results, shall have an intradermal Mantoux using 5TU PPD. This shall be accomplished via the two (2) step procedure. If the first test is negative and the employee is asymptomatic, the employee may engage in resident contact prior to the results of the second skin test. This standard is not met as evidence by: Based on review of personnel files and staff interview, the facility failed to assure tuberculin (TB) testing was completed prior to resident contact for one of five employees. The findings were: Review of personnel files and staff interview revealed the following concerns: a. Employee #1 was hired as a nursing assistant (NA). The employee received a TB skin test on 12/13/10 and the negative results were read on 12/15/10. Review of the nursing schedule with the DON on 2/10/11 at 2:50 PM revealed the employee started working with residents of the	SNH	**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 this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 42 C.F.R. Par 488.18 and section 7317A of the State Operations Manual.** **SNH** **LICENSE REGULATIONS FOR NURSING HOMES** STATE STANDARD Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11 Section 5. Organization and Administration A) The facility will ensure that each New Hire employee will have a tuberculin skin test prior to scheduled work hours within the facility. Verification of same will be maintained the in the employee medical file. B) Tuberculin skin test will be administered prior to any other required personnel paperwork. C) After the first step of the tuberculin test phase is completed with negative results, the employee will be allowed to be scheduled for hours. D) In-service was provided to the Business Office Manager, the In-service Director, and all pertinent Department Managers on February 28, 2011. E) Business Office Manager will not complete the New Hire employee Corporate Approval pay enrollment until tuberculin negative results are in the employee medical file. F) Compliance will be monitored by the Infection Control Nurse with each new hire for a 90 day period. Monthly results will be reported to the QA/QCI Committee at each monthly meeting. At the end of the initial 90 day review period the compliance with regulations will be reviewed and if successful and there are no noted issues, this will be terminated at the July QA/QCI committee meeting. This correction is completed and effective March 1, 2011. If there are noted discrepancies this process will remain in effect.	3/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Fred E Stapleton — TITLE: Administrator — (X6) DATE: 3/7/11

STATE FORM 6899 YOJY11 If continuation sheet 1 of 2

This state POC accepted on 3/21/11 between Administrator (Fred Stapleton) and Tony Mallo

RECEIVED
Wyoming Dept of Health
MAR 07 2011
Office of Healthcare Licensing and Surveys

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SNH	Continued From page 1 facility on 12/11/10, four days before the results of the testing were known.	SNH		

3/21/11