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
	WY0028	A. BUILDING _____ B. WING _____ V 6N 3/19/10	02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 82801

(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: Wyoming Department of Health Aging Division Rules and Regulations For Program Administration of Nursing Care Facilities Chapter 11 Section 5 (b) (iv) (A) Tuberculin testing shall be accomplished for each employee upon employment and before resident contact begins and annually thereafter. This Requirement is not met as evidenced by: Based on staff interview and review of employee health records, the facility failed to ensure 2 of 5 new employees (#6, #11) received tuberculin testing prior to having contact with residents. The findings were: Employee health records for new employees (those hired within the last 180 days) were reviewed. Of five employee records reviewed, two showed employees #6 and #11 had not been tuberculin tested prior to their first scheduled shift with resident contact. Employee #6 began work on 11/15/09 and had an initial tuberculin tested documented on 11/17/09. Employee #11 began work at the facility on 11/8/09, with an initial tuberculin test documented on 11/9/09. The infection control practitioner stated in interview on 2/25/10 at 9:20 AM that the facility required all new hires to test negative for tuberculosis prior to beginning work with a reasonable probability of resident contact. She acknowledged both of these employees would have resident contact in their normal duties.	SNH	Preparation and/or execution of the response and plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this 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 purpose 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 7305 of the State Operations Manual. **STATE: LIC REGS FOR NURSING HOMES** **Corrective Date: 3/15/10** **Corrective Action:** **Identification of Others:** Ongoing audit will be conducted to identify any employees who had contact with residents who had not had TB results read by qualified staff. **Systems/Measures:** 1. All Department Heads were in-serviced by 3/15/10 on the proper sequence of events regarding TB readings and start of work dates. 2. SDC will conduct ongoing audit of all new employees, their hire date, TB readingdate and start to work date.	

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Conaway — TITLE: Administrator — (X6) DATE: 03/17/10

STATE FORM 6899 JXFB11 If continuation sheet 1 of 2

accepted 3/19/10 @ 1628.

RECEIVED Wyoming Dept of Health MAR 22 2010 Office of Healthcare Licensing and Surveys

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WDH - Office of Healthcare Licensing and Surveys

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	WY0028	A. BUILDING _____ B. WING _____ 3/9/10	02/25/2010

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			Monitoring: Data obtained by way of these audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the SDC/designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3.	