PRINTED: 09/27/2018
FORM APPROVED

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 _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1951 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
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 A licensure survey was conducted by Healthcare Licensing and Surveys from 9/10/18 to 9/13/18. The following common abbreviations are used throughout this document. DON: Director of Nursing RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S2910	Ch 11 Sec 5 (b)(iv) Organization and Administration (b) Personnel policies and procedures. The governing body or its equivalent, through the Nursing Home Administrator, shall be responsible for implementing and maintaining written personnel policies and procedures that support sound resident care and personnel practices. (iv) Written policies shall ensure a safe and sanitary environment for residents and personnel. (A) Tuberculin testing shall be accomplished for each employee upon employment and before resident contact begins and annually thereafter.	S2910	S2910 **Corrective Action** RN #4 received a chest x-ray on 9/12/2018 to confirm negative TB status. **Identification of Others** SDC or designee will conduct an audit of all current employees to ensure that tuberculin testing has been performed according to policy by 10/16/2018. Any staff identified that has not received tuberculin testing will receive tuberculin testing according to policy by 10/16/2018.	10/16/2018

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director of Nursing — (X6) DATE: 10/10/18

STATE FORM 6899 Q5G211 If continuation sheet 1 of 5

This plan of correction was accepted with the agreed upon change. Dennis Tufano was notified on 10/12/18 at 4:55 pm. Jean Hennie MT (ASCP)

RECEIVED
OCT 12 2018
Healthcare Licensing and Surveys

PRINTED: 09/27/2018
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0025	A. BUILDING: _____ B. WING _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1951 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
S2910	Continued From page 1 (B) Employees having known positive skin test shall provide a certificate of noninfectiousness for a physician, recommendations, if any, for treatment, and evidence that they have complied with such recommendations. (C) Individuals providing documentation of negative skin tests administered within the last year need no physician follow-up at this time. (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. (I) A negative reaction requires no follow-up by a physician at this time. (II) A positive reaction (10mm induration using 5TU PPD) requires a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if needed. Follow-up shall comply with recommendations of the attending physician. (E) If symptoms occur, a new certificate of noninfectiousness is required from the physician. This State Rule and Regulation is not met as evidenced by: Based on review of employee records, review of policy and procedures, and staff interview, the	S2910	Systemic Change DON will educate SDC on policy regarding tuberculin testing of employees to ensure continued compliance by 10/16/2018. SDC or designee will ensure all new employees receive tuberculin testing according to policy to maintain compliance. Ongoing Monitoring SDC or designee will conduct weekly audits for 4 weeks of all new employees to ensure proper tuberculin testing has been completed and random audits monthly for 2 months to validate continued compliance. Any concerns addressed through the audit process will be monitored and reported by the SDC or designee in summary during the facility monthly QAPI meeting. DON or designee will assess for trends or patterns during these meetings. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance.	

34

PRINTED: 09/27/2018
FORM APPROVED

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 _____	09/13/2018

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
S2910	Continued From page 2 facility failed to ensure tuberculin testing was performed prior to resident contact for 1 of 5 employees (RN #4) reviewed. The findings were: Review of the employee file for RN #4 showed a hire date of 6/8/18. Further review showed a physician statement dated 5/1/2007 (11 years prior to employment with the facility) which stated RN #4 had a negative chest x-ray. Interview with the administrator on 9/12/18 at 11 AM revealed the RN was from a foreign country and had received the BCG vaccine before immigrating. He further stated he assumed the physician statement was adequate. Review of the policy "Tuberculosis Control Plan" revised in 2012 showed "Prospective Employees...6. Individuals who have previously received BCG should be skin tested since BCG positivity generally wanes after 5 years. (Recipients of BCG are usually from high TB prevalence countries.)"	S2910		
S2928	Ch 11 Sec 6 (b)(iii) Physical Environment (b) Sanitary Environment. The Nursing Care Facility shall establish policies and procedures for investigating, controlling and preventing infections. (iii) The facility shall report the required diseases/conditions to the Wyoming Department of Health, Epidemiology Unit as per W.S. §35-4-107. In addition, those conditions classified as nosocomial where two (2) or more persons, either residents or employees, are affected shall be reported immediately to the State Health Officers, the County Health Officer, and the Licensing Division. The Nursing Care	S2928	S2928 **Corrective Action** Symptoms of resident #72, #66, #69, #52, #25, #65, #17, and #31 were reported to the Wyoming Department of Health Epidemiology Unit on 9/11/2018 and reported to Healthcare Licensing and Surveys on 10/12/2018. A copy of the Wyoming Department of Health Reportable Disease and Conditions was obtained for the Infection Control Preventionist on 9/13/2018.	10/16/2018

PRINTED: 09/27/2018
FORM APPROVED

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 _____	09/13/2018

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
S2928	Continued From page 3 Facility Administrator or his/her designated representative shall furnish all available pertinent information related to such disease or condition to the Licensing Division This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, medical record review and review of the Healthcare Licensing and Surveys (HLS) incident log, the facility failed to report an outbreak of an upper respiratory infection to the required agencies which affected 8 of 18 (#17, #25, #31, #52, #65, #66, #69, #72) residents who resided in the memory care unit. The findings were: 1. Observation in the memory care unit on 9/10/18 at 3:56 PM showed resident #72 was assisted by RN #2 with a tissue to wipe his/her nose. Continued observation showed the resident was coughing and sneezing. 2. Observation in the memory care unit on 9/11/18 at 11:28 AM showed resident #17 was coughing. Interview with RN #3 at that time revealed the physician had examined the resident on 9/10/18. Interview with CNA #5 at 11:33 AM revealed residents #25, #65, #69, and #72, in addition to resident #17, were showing signs and symptoms of a respiratory infection. 3. Review of a list of residents compiled by the DON showed the following residents and the date of onset of their respiratory symptoms: a. Resident #72 had a date of onset of 9/5/18. b. Resident #66 had a date of onset of	S2928	**Identification of Others** An audit of all other residents will be conducted to determine if symptoms similar to those listed above are identified by 10/16/2018. **Systemic Change** DON will educate Infection Control Preventionist on reportable diseases and conditions according to the Wyoming Department of Health by 10/16/2018. Any outbreaks falling within the guidelines of the Wyoming Department of Health Reportable Diseases and Conditions will be reported to the Wyoming Department of Health Epidemiology Unit within 24 hours of two or more residents being diagnosed. and to the department of Healthcare Licensing and Surveys. **Ongoing Monitoring** DON or designee will audit all residents weekly x 4 and then monthly for 2 months to determine if any reportable diseases or conditions exist within 2 or more residents to determine continued compliance. Any concerns addressed through the audit process will be monitored and reported by the SDC or designee in summary during the facility monthly QAPI meeting. DON or designee will assess for trends or patterns during these meetings. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance.	JY

JY

PRINTED: 09/27/2018
FORM APPROVED

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 _____	09/13/2018

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
S2928	Continued From page 4 9/8/18. c. Resident #69 had a date of onset of 9/8/18. d. Resident #52 had a date of onset of 9/9/18. e. Resident #25 had a date of onset of 9/11/18. f. Resident #65 had a date of onset of 9/11/18. g. Resident #17 had a date of onset of 9/11/18. h. Resident #31 had a date of onset of 9/11/18. 4. Interview on 9/11/18 at 4:48 PM with the DON and infection control preventionist (ICP) revealed the ICP was unavailable and the DON was monitoring the respiratory infection in the memory care unit. An increase in hand hygiene and environmental sanitation was implemented. However, the Wyoming Department of Health, Epidemiology Unit, and HLS had not been notified. In addition the ICP stated she did not have a copy of the Wyoming Department of Health Reportable Diseases and Conditions. 5. Review of the HLS incident log showed no evidence the outbreak of respiratory illness had been reported. 6. According to the Wyoming Department of Health Reportable Diseases and Conditions last revised January 2018 under "Other Reportable Conditions" showed "Clusters/Outbreaks, GI, respiratory, other illness" are reportable within 24 hours of diagnosis.	S2928		

JY