PRINTED: 12/30/2009
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 _____	12/17/2009

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: Wyoming Department of Health Aging Division 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 upon employment and before resident contact begins and annually thereafter. This Regulation is not met as evidenced by: Based on review of personnel records and staff interview, the facility failed to ensure tuberculin testing was completed on a yearly basis for three of five sample employees reviewed for this test. The findings were: Review of personnel records showed employees #1, #2 and #4 had no record of tuberculin (TB) testing. These employees had been hired since August 2009. During an interview on 12/16/09 at 5:10 PM, the employee health nurse state she wasn't sure if these employees were tested since they could not find documentation of TB tests for these employees.	SNH	Employees #1, #2 and #4 have received TB testing with a non-reactive result. Their employee personnel files have been updated to include the result of that testing. The Infection Control Nurse will audit employee files for completeness prior to new hire personnel being assigned to duty. Audits of the above process Will be conducted by the DON /designee on a Monthly basis and presented At the monthly QA meeting.	2/1/2010

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE MHH — (X6) DATE 1/5/2010

STATE FORM 6899 D33V11 If continuation sheet 1 of 1

This POC accepted on 2/2/10 & agreed to change between R. Dee Cozzens (Administrator) and Tom Mattes

RECEIVED
Wyoming Dept of Health
FEB 01 2010
Office of Healthcare Licensing and Surveys

2/2/10