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 _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENT	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
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 07/01/2020 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 4/1/24 through 4/4/24.	S 000		
S2901	Ch 11 Sec 5 (b) 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. (i) Personnel records for each employee shall be current and available and shall contain sufficient information to support placement in the position assigned. (A) References from former employers and evidence of current certification, licensure, or registration. (B) An evaluation of the employees work performance shall be done yearly. (ii) Written employee policies shall be available coving job descriptions, functions and special procedures. (iii) Written policies shall be in effect to ensure that newly hired and current employees	S2901		4/10/24

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S2901	Continued From page 1	S2901		

do not spread a communicable disease that could be transmitted through usual job duties.

(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.

(B) Employees having known positive skin tests shall provide a certificate of noninfectiousness from 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 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) requites a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if

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S2901	Continued From page 2 needed. Follow-up shall comply with the 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 employee file review, staff interview, and policy and procedure review, the facility failed to ensure annual tuberculin (TB) skin tests or screening was performed for 4 of 6 sample staff members (RN #1, RN #2, CNA #1, and environmental staff member #1). The findings were: 1. Review of the employee file for RN #1 showed there was no evidence of a tuberculin skin test or tuberculin screen since 2/17/2023. 2. Review of the employee file for RN #2 showed there was no evidence of a tuberculin skin test or tuberculin screen since 1/10/23. 3. Review of the employee file for CNA #1 showed there was no evidence of a tuberculin skin test or tuberculin screen since 11/26/22. 4. Review of the employee file for environmental staff member #1 there was no evidence of a tuberculin skin test or tuberculin screen since 5/13/22. 5. Interview with the infection preventionist on 4/4/24 at 9:51 AM confirmed the facility did not have evidence tuberculin testing or screening was performed for the employees. 6. Review of the policy titled "Infection Prevention	S2901	S2901 Corrective Action: 1. The facility screened RN #1, RN#2, CNA #1, and environmental staff #1 who were found to not have current TB screenings during survey on 4/4/24. All staff regardless of last TB screening were screened on or before 4/10/2024. Identification of others: 2. Residents that reside at Big Horn Health and Rehabilitation Care Center are at risk. All staff at Big Horn Rehabilitation Care Center completed TB screening with compliance on or before 4/10/2024 and no further issues identified. Systemic Changes: The DON/ designee will educate the infection control nurse, HR director on or before the date of compliance regarding TB screening for staff and community risk assessment. The facility will ensure all staff upon hire and annually will either be screened for TB or receive a TB skin test as required to meet this regulation. DON/ designee will do random audits two times a week for one month, then weekly for one month, then monthly for one month and as needed, for a minimum of twelve weeks. Any concerns identified will be addressed immediately. Monitoring:	

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S2901	Continued From page 3 and Control Program" dated 1/1/24 showed "...14. Staff Communicable Disease Screening and Immunization: a. Direct care stall shall comply with physical examinations and immunization screening requirements upon employment, and annually. b. Direct care staff shall be tested for TB upon hire. Routine, serial TB testing of staff will not be conducted except in the case of ongoing transmission or known exposure in the facility..."	S2901	Any issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure the plan is implemented, sustained, and evaluated for its effectiveness until substantial compliance is met. Date of compliance: April 10, 2024.	