STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING **01** B. WING _____	**07/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET** **CHEYENNE, WY 82001**

(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) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on July 15, 2021. .	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on July 15, 2021. Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (000) construction built in 1961. The building was equipped with a supervised automatic wet sprinkler system with an wet antifreeze sprinkler system, and an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 97 residents. .	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		8/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be	K 222		

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K 222	Continued From page 2 permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous delayed egress doors. The findings were: Observation on 7/15/2021 at 9:21 AM revealed that the egress door, across from the activities office, was equipped with delayed-egress hardware but was not marked with a delayed-egress sign. All doors equipped with delayed-egress hardware shall have a readily visible sign located on the door leaf, adjacent to the release device, that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN E OPENED IN 15 SECONDS". Interview with the facilities manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 222	Based on observation and staff interview, the facility failed to maintain delayed egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of delayed egress doors. The findings were: Observation on 7/15/2021 at 9:21 AM at the door across from the activities office was equipped with a delayed egress system, which operated as prescribed, but did not have a readily visible, durable sign to identify the equipped door. Interview with the facilities manager at the time of observation acknowledged the delayed egress failure, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	

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K 222	Continued From page 3 REF: 2012 NFPA 101, Sections: 19.2.2.2.4; 7.2.1.6.1.1 (4)	K 222	REF: 2012 NFPA 101, Sections: 19.2.2.2.4; 7.2.1.6.1.1 (4) Preparation or execution of this plan of correction does not constitute 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 the provisions of federal and state law require it. The plan of correction serves as the facility□s allegation of compliance. K 222 Egress Doors CORRECTIVE ACTION A readily visible durable delayed egress sign was placed on the door across from the activity office on 7/21/21. IDENTIFICATION OF OTHERS The Maintenance Director/designee checked all other facility delayed egress doors to verify all had readily visible durable signage on 8/2/21. No other concerns were identified. SYSTEMIC CHANGES The Maintenance Director/designee checks all facility delayed egress doors for signage monthly to ensure signage is still	

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K 222	Continued From page 4	K 222	in place monthly. If a concern is identified the signage is replaced. Education was provided to the Maintenance department related to readily visible, durable signage on all delayed egress doors on 8/3/21 by the Administrator. This monitoring will continue for 3 months. MONITORING The Maintenance Director reports any identified concerns with the delayed egress door signage to the Quality Assurance Performance Improvement for their review and resolution. The monitoring will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321		8/20/21

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K 321	Continued From page 5 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could result in injury or death in the event of a fire. The deficiencies affected three (3) of numerous rooms in the facility. The findings were: Observation on 7/15/2021 at 9:25 AM revealed an excessive amount of combustible storage located in the activities office. The room was fully sprinklered but the doors were not self-closing. All hazardous areas that are protected with an automatic extinguishing system shall have self or automatic-closing doors. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time	K 321	K 321 Hazardous Areas-Enclosure CORRECTIVE ACTION A self-closure mechanism was placed on the activity room door on 7/16/21. A new fire rated door was ordered on 8/4/21 for the identified boiler room. The facility has requested a Time Limited waver for this portion of K321. The paint was removed from the laundry room door to expose the approved label to a legible condition. The pass-through window in the south soiled utility room will be sealed prior to 8/10/21	

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K 321	Continued From page 6 of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2.1, 19.3.2.3 Observation on 7/15/2021 at 12:41 PM revealed that the boiler room door was part of the fire door assembly but was missing the approved label. Further observation revealed that the laundry room door was also intended to be part of a fire door assembly and the approved label appeared to have been painted over and no longer legible. All fire door assemblies are required to bear an approved label which is to be maintained in a legible condition. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2.1.5, 8.3.3.2.2, 8.3.3.2.3 Observation on 7/15/2021 at 10:57 AM revealed the soiled utility room south, had a pass through window opening to the adjacent storage room. The pass through window did have a means of self or automatic closing. All doors in a hazardous area that are protected with an automatic extinguishing system shall be self or automatic-closing in order to limit the transfer of smoke. Interview with the maintenance director at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.	K 321	IDENTIFICATION OF OTHERS The Maintenance Director/designee checked all hazardous areas that are protected by with an automatic extinguishing system to ensure all have a self or automatic-closing door. The Maintenance Director checked all fire doors for approved label. No other doors are missing the approved label. There is no pass-through window in the other soiled utility room. SYSTEMIC CHANGES The Maintenance Director/designee checks all hazardous areas monthly to ensure all have functioning self-closing doors. These audits will continue for 3 months. The Maintenance Director/designee checks all fire doors for the approved label monthly to ensure that all fire doors have the approved label appropriate legible. The Maintenance Director/designee checks all storage areas monthly to ensure that there are no new open window areas. These audits will be done for 3 months. Education was provided to the Maintenance department related to the requirement of hazardous areas that are protected by an automatic extinguishing	

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K 321	Continued From page 7 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2.1, 19.3.2.1.2, 19.3.2.1.3 .	K 321	system having a self-closing door on 8/3/21 by the Administrator. This monitoring will continue for 3 months. Education was provided to the Maintenance department related to ensuring that all approved labels are always legible by the Administrator on 8/3/21. Education was provided to the Maintenance Department related to identifying and closing up any pass-through windows in hazardous areas by the Administrator on 8/3/21. MONITORING The Maintenance Director reports any identified concerns with the hazardous areas protected with an automatic extinguishing system having an automatic closing door, verification of the approved labels on the fire doors are legible and verification of no additional window openings to the Quality Assurance Performance Improvement for their review and resolution. The monitoring will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		8/20/21

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K 353	Continued From page 8 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. Failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected the entire facility. The findings were: Observation on 7/15/2021 at 9:46 AM and throughout the survey revealed multiple rooms, including room 145, with objects stacked in the closet to within a few inches of the sprinkler head so that it would obstruct the sprinkler's discharge pattern. Storage shall be placed so that in the event of a fire it does not obstruct the spray pattern of any sprinklers. Interview with the facility maintenance manager at the time of observation acknowledged the	K 353	K 353 Sprinkler system CORRECTIVE ACTION The closet in room 145 was cleaned to prevent obstruction of the sprinkler□s discharge pattern. IDENTIFICATION OF OTHERS An audit was conducted by the Maintenance Director/designee to identify any closets that had objects obstructing the sprinkler discharge pattern. Any identified closets were cleaned to prevent obstruction. SYSTEMIC CHANGES Education was provided to the staff	

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K 353	Continued From page 9 deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2 .	K 353	regarding preventing obstruction of the sprinkler□s discharge pattern on 8/3/21 by NHA The Maintenance Director/Designee conducts rounds weekly to ensue that no closets have objects that obstruct the sprinkler□s discharge pattern. Any identified concerns are corrected at that time. These rounds will continue for 3 months. MONITORING The Maintenance Director reports any identified concerns related to objects obstructing the sprinkler□s discharge pattern to the Quality Assurance Performance Improvement for their review and resolution. The monitoring will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install fire extinguishers in accordance with the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to install fire	K 355	K 355 Portable Fire Extinguishers	8/20/21

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K 355	Continued From page 10 extinguishers as required could result in injury or death in the event of a fire. The deficiencies affected one (1) of numerous fire extinguishers in the facility. The findings were: Observation on 7/15/2021 at 11:20 PM by the outside smoking area found the fire extinguisher installed at a height of 63". Portable fire extinguishers shall be installed so that the top of the fire extinguisher is not more than 5 feet above the floor. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 10: Section 6.1.3.8.1 .	K 355	CORRECTIVE ACTION The fire extinguisher was lowered to the correct height on 7/30/21. IDENTIFICATION OF OTHERS The Maintenance Director/Designee checked all fire extinguishers in the facility to ensure that all are the correct height on 8/3/21. All others were the correct height from the ground. SYSTEMIC CHANGES Education was provided to the Maintenance Department on 8/3/21 regarding the proper required height of fire extinguishers from the floor by the Administrator. The Maintenance Director/Designee verifies the height of the fire extinguishers from the ground monthly to ensure there has been no change. This audit will continue for 3 months. MONITORING The Maintenance Director reports any identified concerns related to the mounted height of the fire extinguishers to the Quality Assurance Performance Improvement for their review and resolution. The monitoring will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

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K 362	Continued From page 11	K 362		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain corridor walls as required could result in injury or death during an emergency. The deficiencies affected one (1) of numerous corridor walls in the facility. The findings were: Observation on 7/15/2021 at 9:23 AM revealed unprotected plumbing penetrations located above the staff bathroom door, adjacent to the activities office and the kitchen. Corridor walls shall form a	K 362	K 362 Corridors-Construction of Walls CORRECTIVE ACTION The penetration located above the staff bathroom door adjacent to the activity office and kitchen was caulked to limit the transfer of smoke on 7/16/21. IDENTIFICATION OF OTHERS	8/20/21

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POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET** **CHEYENNE, WY 82001**

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K 362	Continued From page 12 barrier to limit the transfer of smoke. Interview with the facilities manager at the time of observation acknowledged the penetrations, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.6.2.3 .	K 362	The Maintenance Director/Designee conducted an audit of the facility to identify any other areas of penetration that would allow the transfer of smoke on 8/3/21. No additional penetrations were identified. SYSTEMIC CHANGES The Maintenance Director/Designee conducts monthly rounds in the facility to identify any penetrations that would allow for the transfer of smoke. Any identified concerns are corrected immediately. Education was provided to the Maintenance Department on 8/3/21 regarding the requirement to ensure that all penetrations have a barrier to limit the transfer of smoke by the Administrator MONITORING The Maintenance Director reports any identified concerns related to unprotected penetrations to the Quality Assurance Performance Improvement for their review and resolution. The monitoring will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable	K 920		8/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING **01** B. WING _____	**07/15/2021**

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K 920	Continued From page 13 patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 99, Health Care Facilities. Failure to maintain electrical equipment as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 7/15/2021 at 10:15 AM, revealed that resident room 132 had a power strip located within the patient care vicinity. The resident room contained patient care related electrical equipment. Power strips cannot be located within the patient care vicinity in resident rooms that use patient care related electrical equipment.	K 920	K 920 Electrical Equipment-power cords CORRECTIVE ACTION The power strip located in room 132 was removed on 8/3/21 IDENTIFICATION OF OTHERS The Maintenance Director/Designee audited all resident rooms to ensure that no rooms had a power strip located within the patient care vicinity with patient care electrical equipment on 8/3/21. Any identified concerns were corrected	

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K 920	Continued From page 14 Interview with the maintenance director at time of observation acknowledged the deficiencies, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.1.2 2012 NFPA 99, Section 10.2.3.6 2011 NFPA 70, Section 400.8	K 920	immediately. SYSTEMIC CHANGES Education was provided to the Maintenance Department on 8/3/21 regarding the requirement not to have power strips int the patient care vicinity in rooms with patient care related electrical equipment. The Maintenance Director/Designee audits the resident rooms weekly to ensure that no power strips are located in patent care vicinity in resident rooms that use patient care related electrical equipment. Any identified concerns are corrected at the time of the audit. These rounds will continue for 3 months. MONITORING The Maintenance Director reports any identified concerns related to power strips located within patient care vicinity in resident rooms that use patient care related electrical equipment to the Quality Assurance Performance Improvement for their review and resolution. The monitoring will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	