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 _____	**01/05/2022**

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 January 5, 2022. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements. .	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on January 5, 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 a 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 81 residents. .	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is	K 211		1/31/22

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

Electronically Signed | 01/31/2022

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K 211	Continued From page 1 continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous exits. The findings were: Observation on 1/5/22 at 9:13 AM at the north east exit revealed that the sidewalk was covered snow. Interview with the director of nursing at time of observation acknowledged the deficiency, and indicated they were unaware of the deficiency. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.3.1; 7.1.10.1 .	K 211	K211 (D) Means of Egress This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris Rehab and Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements Correction - The snow removal company was notified immediately, and the snow was removed from the Northeast exit sidewalk. Identification - The Administrator walked the exterior of the building and checked all exits to insure clear egress and compliance. The snow removal company was educated on the regulation and our expectation of having all exits cleared of snow as needed when snowing. Systemic – The maintenance department and snow removal company were educated on the regulation as well as our	

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K 211	Continued From page 2	K 211	expectation of having all exits cleared of snow in addition to the sidewalks. Monitoring – The Maintenance Director or Designee will check each exit for snow removal throughout a snowstorm to ensure that each exit has a safe clear means of egress and review and discuss in monthly QAPI for 3 months (January, February and March 2022). Date of Compliance – 1/5/2022	
K 222 SS=D	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 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	K 222		1/31/22

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K 222	Continued From page 3 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 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 result in injury or death during an	K 222	K222 (D) Egress Doors This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris Rehab and Care Center does not admit	

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K 222	Continued From page 4 emergency. The deficiency affected exit doors equipped with delayed egress throughout the facility. The findings were: Observation on 1/5/2025 at 8:34 PM at the southeast exit, by room 105, revealed the delayed egress locking system failed to operate as designed. When tested the required force to activate an irreversible process to release the door was in excess of 35 lbf. Further observation found this issue to be present throughout the facility. Interview with the director of nursing at the time of observation acknowledged the excess force, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(3)(a) .	K 222	that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements Correction – All doors were checked and adjusted to require about 15lbs of force to open. Identification – Maintenance Director checked all delayed egress locking doors and adjusted to less than 15lbs of force required to open and checked for proper delayed egress operation. Systemic – Maintenance Director educated on requirement by Administrator. Monitoring – The Maintenance Director added checking these delayed egress locking doors for correct operating pressure to monthly TELS and will review and discuss at monthly QAPI for 3 months (January, February and March 2022). Date of Compliance – 1/10/2022	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous	K 223		1/31/22

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K 223	Continued From page 5 area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a self-closing door that latched in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a latching self-closing door as required could delay egress resulting in injury or death during an emergency. The deficiency affected two (2) of numerous doors in the facility. The findings were: Observation on 1/5/2022 at 9:00 AM at the fire doors next to dietary office revealed that the doors failed to latch. When tested from the magnetic hold location with no initial motion, it was found that the doors failed to fully close and latch. Additional observation found the kitchen door by the dietary office also failed to close when tested in the same manner. Interview with the director of nursing at the time of observation acknowledged the excess force, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 223	K223 (D) Doors with Self Closing Devices This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris Rehab and Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements Correction – Adjusted doors near dietary and observed for proper operation. They closed and latched as designed. Identification – Maintenance Director checked all doors with self-closing devices for proper operation and adjusted	

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K 223	Continued From page 6 REF: 2012 NFPA 101: Section 7.2.1.8.2 .	K 223	as needed. Systemic – Maintenance Director educated on requirement by Administrator. Monitoring – The Maintenance Director added checking doors with self-closing devices to monthly TELS and will be discussed and reviewed at Monthly QAPI meeting for 3 months (January, February and March). Date of Compliance – 1/10/2022	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard	K 351	K351 (D) Sprinkler System Installation This Plan of Correction is prepared and submitted as required by law. By	1/31/22

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K 351	Continued From page 7 for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency was in one (1) of numerous rooms. The findings were: Observation on 1/5/2022 at 10:00 AM in the resident care management director's office, revealed an obstruction near the sprinkler head. The obstruction was a large fan to the room center of the sprinkler head. Interview with the director of nursing at the time of observations acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 13, Sections: 8.6.5 .	K 351	submitting this Plan of Correction, Polaris Rehab and Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements Correction – Removed the ceiling fan from the MDS office and installed a light. The light is in a position not to disrupt the flow from the sprinkler system and exceeds regulatory requirements. Identification – Maintenance Director inspected building for additional obstructions to the fire system. Systemic – Maintenance Director was educated proper spacing required around fire system sprinkler heads. Monitoring – No additional ceiling fans or things of the like will be installed without the approval of the Maintenance Director or Administrator. Date of Compliance – 1/7/2022	
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	K 353		1/31/22

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K 353	Continued From page 8 with NFPA 25, Standard for the Inspection, 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 the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency was throughout the facility. The findings were: Observation on 1/5/2022 at 9:17 AM in room 147, ice room, revealed a fire sprinkler head with an escutcheon that was not flush to the ceiling, exposing the annual space. Escutcheons shall be used to cover the annular space around the sprinkler head. Interview with the director of nursing at the time of observations acknowledged the deficiencies, and indicated they were unaware of the requirement. Interview with the facility administrator at the time	K 353	K353 (D) Sprinkler System Maintenance and Testing This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris Rehab and Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements Correction – The Escutcheon in the ice	

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K 353	Continued From page 9 of exit acknowledged the deficiency. REF: 2010 NFPA 13, Sections: 6.2.7.1 .	K 353	room was adjusted to the ceiling. Identification – Maintenance Director inspected each escutcheon in the facility and adjusted them to ceiling if needed. Systemic – Maintenance Director was informed of regulation. Monitoring – Maintenance Director added checking escutcheons to monthly TELS and tag will be discussed in monthly QAPI for 3 months (January, February and March). Date of Compliance – 1/7/2022	
K 751 SS=D	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide patient curtains in accordance with the 2012 NFPA 101, Life Safety Code. The failure to provide patient curtains as required could cause an increased fire risk, and result in injury or death. The deficiencies affected the entire facility. Observations on 1/5/2022 between 8:00 AM and	K 751	K751 (D) Draperies, Curtains, and Loosely Hanging Fabrics This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris Rehab and Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions	1/31/22

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K 751	Continued From page 10 10:30 AM in resident rooms found that the privacy curtains did not state they meet requirements of NFPA 701. Curtains are present throughout the facility. The curtains at one time had a tag but they had been washed out, the facility did not have paperwork to demonstrate compliance with NFPA 701 requirements. Interview with the director of nursing, and the administrator, 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, Sections: 19.7.5.1; 10.3.1 .	K 751	that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements Correction – Administrator checked entire facility for a privacy curtain with a readable tag indicating NFPA 701 compliance and found a legible tag. Identification – Found a legible tag on a privacy curtain and took a photo and attached it to this POC. Systemic – Maintenance Director and Laundry/Housekeeping were educated on the regulation. Monitoring – Maintenance Director will check all new Curtains and fabrics for NFPA 701 compliance prior to purchase and installation and save invoice and paperwork. Date of Compliance – 1/5/2022	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K 761		1/31/22

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

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K 761	Continued From page 11 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain openings in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain openings as required could result in injury or death during an emergency. The deficiency affected one (1) opening out of many throughout the facility. The findings were: Observation on 1/5/2022 at 9:01 AM at the fire doors next to the dietary office revealed that the left door, when looking north, was missing the listing tag. Interview with the director of nursing at the time of observation acknowledged the missing tag, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.5, 7.2.4.3.1, 8.3.3.1, 8.3.3.2, 8.3.3.2.2 .	K 761	K761 (D) Maintenance, Inspection and Testing – Fire Doors – Cert Tag Missing This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris Rehab and Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements Correction – Removed door and took it to Certified Fire Door Professional (WY Doorways) for inspection and a recertification tag. The door passed testing and was recertified with a new tag. Photo attached and invoice attached. Installed Door with approved tag, adjusted, and verified proper operation. Identification – Maintenance Director inspected all Fire Doors for the proper	

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 _____	**01/05/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 761	Continued From page 12	K 761	identification and certification tag. Systemic – Maintenance Director was refreshed on regulation. Monitoring – Maintenance Director added monthly Fire Door Tag inspection to TELS. Date of Compliance – 1/31/2022	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		1/31/22

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	535025	A. BUILDING **01** B. WING _____	**01/05/2022**

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K 918	Continued From page 13 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test the generator batteries in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to test and maintain the generator battery could result in the generator not functioning in an emergency. The deficiency affected the generator battery. The findings were: Document review on 1/5/2022 at 12:00 PM revealed it could not be established that the battery electrolyte specific gravity or battery conductance testing had been checked in the past 12 months. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 110, Sections: 8.3.7.1	K 918	K918 (D) Electrical Systems – Essential Electrical Systems This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris Rehab and Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements Correction – Performed generator battery test and recorded readings. Identification – Maintenance Director inspected generator battery and tested. Systemic – Maintenance Director was educated on regulatory requirement. Monitoring – Maintenance Director added Generator Battery Test readings to the monthly generator test in TELS. Date of Compliance – 10/7/2022	