STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/3/22 to 1/6/22. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide CMS- Centers for Medicare and Medicaid Services DON- Director of Nursing IP- Infection Preventionist MAR- Medication Administration Record MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse TAR- Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		2/9/22

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

Electronically Signed | 01/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 656	Continued From page 1 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, and medical record review, the facility failed to ensure comprehensive care plans were completed for 2 of 21 sample residents (#25, #33). The findings were: 1. Review of the 10/8/21 quarterly MDS assessment showed resident #25 had diagnoses which included end stage renal disease,	F 656	F656 Care Plans 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 656	Continued From page 2 dependence on renal dialysis, cerebral infarction, type 2 diabetes mellitus, peripheral vascular disease, morbid obesity, dysphagia, congestive heart failure and muscle weakness. The review showed the resident had a BIMS score of 14 out of 15 (cognitively intact). The review further showed the resident did not have pain. The following concerns were identified: a. Interview on 1/4/22 at 9:17 AM with the resident revealed s/he had frequent pain and felt the facility was not doing enough to help with the pain. The resident further stated s/he was not having regular bowel movements. b. Review of the care plan with a revision date of 11/9/21 showed a problem care area for pain, but failed to show interventions to help alleviate pain. c. Review of the care plan showed a problem care area for bowel incontinence, but failed to show interventions to alleviate constipation. d. Interview on 1/5/22 at 3:21 PM with the DON confirmed the care plan was generic and not resident-centered. 2. Review of the 10/25/21 admission MDS assessment showed resident #33 was cognitively intact with a BIMS score of 15 out of 15, and had diagnoses that included diabetes mellitus, low back pain, and other chronic pain. The assessment showed the resident was on a scheduled pain medication regimen and received as needed (PRN) pain medications. The pain was shown to be frequent, limited day-to-day activities, and was rated as 6 out of 10 for intensity. Review of section V showed areas that triggered for further assessment and were determined to need care planning included: Falls, Pressure Ulcer Risk, and Pain. The following concerns were identified:	F 656	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: Resident # 25, has had a new Pain Assessment completed and her care plan has been completed to include more specific interventions and now has a care plan in place to address her constipation. Resident # 33, has had their Pain, Pressure Ulcer and Fall comprehensive care plans completed. Identification: Residents currently residing in the facility who are in need for and have a pain care plan, that is not specific enough or those who are past 21 days without a comprehensive care plan have been reviewed. They have had their care plans updated to ensure that they are specific and that all residents who have been in the facility past day 21 have a comprehensive care plan. Systemic: The Interdisciplinary Team have been educated by the Director of Clinical Operations on the completions of the Comprehensive care plans by day 21. Included in this education is the importance of care plans being specific to the residents themselves. Nurses have been educated on informing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 656	Continued From page 3 a. Review of the care plan showed it failed to address the area of pain. In addition, there was no mention of falls or pressure ulcer risk. b. Interview with the DON on 1/6/22 at 2:04 PM confirmed the care plan was not developed to include the pain issue. She stated the MDS nurse had quit and they were catching up on the comprehensive care plans since the new coordinator took over on 12/13/21.	F 656	the MDS coordinator, DON or Unit Manager of any preferences that the resident may have that would be beneficial to have on the PCC. These IDT Members will then add these preferences/specifics to the care plan and trigger them to the appropriate discipline via point of care, dietary, Social Services etc. MDS Coordinator is tracking and reporting on the comprehensive care plans that are due daily at the AM Morning Meeting and will continue to monitor the progress until they are continue. Monitoring: The MDS Coordinator will report on the process of the timely completion of the comprehensive care plan utilizing the tracking system through the AM Morning meeting to the QAPI Committee monthly x3 to ensure that the process remains in compliance. Date of Compliance: 2/9/2022	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 657	Continued From page 4 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure resident participation in care plan development for 1 of 21 sample residents (#25). The findings were: Review of the 10/8/21 quarterly MDS assessment showed resident #25 had diagnoses which included end stage renal disease, dependence on renal dialysis, cerebral infarction, type 2 diabetes mellitus, peripheral vascular disease, morbid obesity, dysphagia, congestive heart failure and muscle weakness. Further review showed a BIMS score of 14 (cognitively intact). The following concerns were identified: a. Interview with the resident on 1/4/22 at 9:29 AM revealed s/he had not been invited to, nor did s/he attend a care planning conference. b. Review of the medical record showed the last care conference meeting was on 4/15/21. c. Interview with social worker #1 on 1/6/22 at 3:08 PM confirmed there was no documentation	F 657	F657 Care Conferences: D. May no notes, 4/21 last doc 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 Interdisciplinary Team has invited	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 657	Continued From page 5 of additional care planning meetings, or resident involvement in care plan development.	F 657	Resident #25 and her POA to attend a care conference, to assist her to meet/maintain her goals, choices and preferences. Identification: Residents currently residing in the facility have been reviewed to ensure that they have had a care conference within the last quarter. Those who had not will be scheduled by the Social Service Director, an invitation to the resident and family member will be given. Systemic: Social Service Director and MDS Coordinator will be educated on development of creating a care conference schedule based off of the MDS/RAI schedule and also the need or request of the resident and or POA. Social Services will be educated on sending out invitations to the Residents and/or POAs. Social Service Director and MDS Coordinator will develop a tracking system to ensure that every resident has had care plan meeting within a quarters timeframe. Care conference schedule will be reviewed, by the SSD, at the daily AM meeting. Monitoring: The SSD will report on the tracking system and process for monitoring of care conferences, to the QAPI, to ensure that process is maintained. Date of Compliance: 2/9/2022	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 677	Continued From page 6 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure baths or showers were provided in a timely manner for 2 of 6 sample residents (#77, #79) who required assistance with ADLs. The findings were: 1. Review of the 11/29/21 annual MDS assessment showed resident #79 was admitted to the facility on 1/15/21 with diagnoses which included heart failure, end stage renal disease, chronic obstructive pulmonary disease, anxiety disorder, and depression. The review showed the resident was cognitively intact with a BIMS score of 14 out of 15. The review showed the resident required extensive assistance of 1 staff member for personal hygiene, and transfer assistance of 1 staff member with support for showers and baths. The following concerns were identified: a. Observation on 1/4/22 at 10:11 AM showed resident #79 appeared to have unwashed oily hair. b. Review of the resident's shower documentation showed s/he received no showers from 12/1/21 to 12/22/21 (20 days), on 12/22/21 the resident was documented as having refused a shower. The resident received a shower on 12/28/21. No recent showers were documented between 12/29/21 and 1/5/22. c. Interview with the resident on 1/4/22 at 11:06 AM confirmed the facility failed to provide a shower or bath weekly, and s/he stated it was due to inadequate staffing. d. Interview on 1/6/22 at 3:56 PM with the	F 677	F677Bath/Showers: 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 Corrective Action: Resident #77 and #79 are receiving showers twice per week according to the shower schedule. Identification of Others: All residents residing in the facility have the potential to be affected by this practice. Systemic: Licensed staff and CNA□s have been educated by the DON/Designee on the requirements of bathing residents and documentation of acceptance or declination. This education will be completed by 2-9-22. Shower aids will be assigned to bathe residents daily according to the shower schedule. DON/Designee will review the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 677	Continued From page 7 DON revealed she felt CNAs failed to document baths and showers consistently. 2. Review of the 11/26/21 quarterly MDS assessment showed resident #77 was admitted to the facility on 5/11/21 with diagnoses which included Alzheimer's dementia, cerebral vascular accident, malnutrition, and depression. The review showed the resident had no BIMS score due to severe cognitive impairment. The review further showed the resident required extensive assistance of 1 staff member for personal hygiene, and 1 staff member assistance for showers and baths. The following concerns were identified: a. Review of the resident's shower documentation showed s/he received no showers or baths from 12/10/21 through 1/5/22 (26 days). b. Interview on 1/6/22 at 3:56 PM with the DON revealed she felt CNAs failed to document baths and showers consistently.	F 677	shower schedule and bathing documentation 5 days per week to ensure that all residents have been offered a bath/shower as scheduled and that it has been documented accordingly. Monitoring: The DON will report any identified patterns related to missed bathing to the QAPI Committee monthly. Tracking will continue for 3 months unless the QAPI Committee deems it necessary to continue. Date of Compliance 2-9-22	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 690	Continued From page 8 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to effectively treat constipation for 2 of 3 sample residents (#10, #25) reviewed. The findings were: 1. Review of the 10/8/21 quarterly MDS assessment showed resident #25 had diagnoses which included end stage renal disease, dependence on renal dialysis, cerebral infarction, type 2 diabetes mellitus, peripheral vascular disease, morbid obesity, dysphasia, congestive heart failure and was incontinent of bowel movements. Review of the MAR for December 2021 showed orders for magnesium hydroxide suspension 400 mg/5 milliliters (ml) 30 ml every 24 hours as needed (PRN) for constipation, and miralax powder 17 Grams (GM) every 24 hours	F 690	F690 Incontinence B&B 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 690	Continued From page 9 as needed for constipation. The following concerns were identified: a. Interview on 1/4/21 at 9:20 AM with the resident revealed s/he did not have regular bowel movements. b. Review of the December 2021 TAR showed the resident did not have a documented bowel movement for 6 days from 12/7/21 to 12/12/21. Further review showed the resident did not have a documented bowel movement for 9 days from 12/23/21 to 12/31/21. c. Review of the December 2021 MAR showed neither the PRN magnesium hydroxide suspension nor the PRN miralax had been administered. d. Review of the care plan failed to identify a problem or interventions related to constipation. e. Interview on 1/5/21 at 11:30 AM with LPN #1 stated when residents haven't had a bowel movement, they are started on a "bowel protocol." 2. Review of the 9/28/21 annual MDS assessment showed resident #10 was admitted with diagnoses which included atrial fibrillation, hypertension, chronic obstructive pulmonary disease, and a pacemaker. Further review showed the resident was frequently incontinent of bowel movements. The following concerns were identified: a. Review of the December 2021 TAR showed the resident did not have a documented bowel movement for 6 days from 12/7/21 to 12/13/21. Further review of the TAR showed no documented bowel movement for 6 days from 12/23/21 to 12/29/21. b. Review of the December 2021 MAR failed to show orders for a stool softener. c. Review of the care plan failed to identify a problem of constipation, nor did it show	F 690	compliance with federal Medicare and Medicaid requirements Correction: Resident #10, has not shown any signs/symptoms of constipation. Their care plan has been reviewed by Interdisciplinary Team (IDT). Resident #25, has not shown any signs/symptoms of constipation. Their care plan has been reviewed by Interdisciplinary Team (IDT). Identification: Current residents receiving narcotics and/or with a Dx of Constipation have had their care plans updated and an order for bowel protocol placed. All other current residents have a new order for bowel protocol. Systemic: Licensed staff will be educated prior to the date of compliance, 2/9/22, regarding the new bowel protocol. DON/Designee will audit current residents BM□s 5x/wk x 8 wks and 3x/ wk x 4 wks to ensure bowel protocol is being followed. Monitoring: DON/Designee will submit a report to the QAPI Committee identifying any issues identified as a result of the review. This will occur monthly x 3 months to ensure this process is maintained. Date of compliance 2/9/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 690	Continued From page 10 interventions to treat constipation. d. Interview on 1/6/22 at 4:27 PM with the DON confirmed there were no orders for stool softeners. 3. Interview on 1/5/21 at 3:12 PM with the DON revealed all shifts were expected to document the status of a resident's bowel movement. She further stated the facility did not have a "bowel protocol." She stated the expectation was for the nurse to pull a bowel report for residents and administer stool softeners as needed to treat constipation.	F 690		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.	F 700		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 700	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to ensure bed rails were evaluated for risk of entrapment for 1 of 2 sample residents (#36) reviewed for bed rails. The findings were: Review of the 11/2/21 admission MDS assessment showed resident #36 was cognitively intact with a BIMS score of 15 out of 15. The resident required extensive assistance of one staff member to assist for bed mobility and transfers. The assessment showed there were no bed rails or other restraints or alarms used. The following concerns were identified: a. Observations on 1/5/22 at 10:44 AM showed the resident was in bed and there was a side rail attached to the left side of the bed which was away from the wall. The rail was attached at the head of the bed and extended part way down the length of the mattress. The rail included gaps between the bars. b. Interview with the resident on 1/4/22 at 9:08 AM revealed the side rails were already on the bed when s/he was admitted. c. Review of the medical record failed to show an assessment or evaluation related to the use of the side rails and any risk for entrapment. d. Interview with the regional nurse on 1/05/22 at 2:05 PM revealed the facility had not performed an assessment to determine the risks associated with this resident's use of a side rail.	F 700	F700 Bedrails 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: Resident #36 was removed from the bed with the side rail on it and placed in a bed with a grab bar due to his preference to have one to assist him with positioning. A pre-physical restraint assessment was completed at the time of the survey. Identification: Residents currently residing in the facility with side rails on their bed have been reviewed to ensure that pre physical restraint assessment has been completed on them. Their care plan has been reviewed by IDT to make sure it is up to date. Systemic: Interdisciplinary Team has been educated by on initiating appropriate assessments	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 700	Continued From page 12	F 700	when they initiate side rails or assist bars that may cause a safety concern to the resident, this education was completed by the Director of Clinical Operations on 1/31/22. Facility Nurses have been educated on the appropriate assessments to complete, when why and how often they need to be completed. This will be done by the DON/designee by 2/9/22. Ambassadors are making rounds on their designated residents at least 3x per week, at different times of the day. They will specifically look for issues with side rails and assist bars that may be considered a safety concern to the resident. Ambassador Rounds are reviewed at the AM Morning Meeting Monday through Friday, issues noted during these rounds will be brought up so that the IDT can follow up and ensure assessments are in place. Monitoring: The NHA/designee will track and trend any side rail and assist bar issues that have been brought up at AM meeting and will submit a report to the monthly QAPI Committee X3 to ensure that compliance is maintained. Date of Compliance 2-9-22	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 725		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 725	Continued From page 13 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, review of staffing schedules, review of bathing documentation, medical record review, review of resident council meeting minutes, and policy and procedure review, the facility failed to ensure adequate staff to meet the needs of the residents. The census was 83. The findings were: 1. Review of the staffing schedule showed three shifts for CNAs. Day shift from 6 AM to 2 PM, evening shift from 2 PM to 10 PM, and night shift from 10 PM to 6 AM. The staffing plan was to staff two CNAs for each of the four resident hallways on day shift and the evening shift, for a	F 725	F725 Sufficient Nursing Staff This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris Rehab and 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 725	Continued From page 14 total of 8 CNAs per shift. Night shift was to have one CNA per each of the four hallways for a total of 4 CNAs. The following concerns were identified: a. Review of the 12/22/21 schedule showed the evening shift (2PM to 10 PM) had one vacant assignment for a CNA on the northwest hall; and one assignment was filled by a "CNA in training" on the northeast hall. This resulted in 7 CNAs and one "CNA in Training" for the shift. b. Review of the 12/26/21 schedule showed the day shift (6AM to 2PM) had one vacant assignment for a CNA on the southeast hall, and one vacant assignment for the southwest hall. This resulted in only 6 CNAs for the shift. The evening shift (2PM to 10PM) for this day had one vacant assignment for a CNA on the northeast hall, and one vacant assignment on the southeast hall which resulted in only 6 CNAs for the shift. c. Review of the schedule for 12/31/21 showed the day shift (6 AM to 2 PM) had one vacant assignment for a CNA on the northeast hall. Continued review of the day shift schedule for 12/31/21 showed the southwest and southeast halls had vacant assignments for three CNAs which resulted in only 4 CNAs for the shift. d. Review of the 1/4/22 schedule for the day shift and evening shift showed the southwest and southeast halls had three vacant CNA assignments. Further review of the 1/4/22 schedule for the evening shift showed the northwest and northeast halls had two vacant CNA assignments with a "CNA in training" floating between the halls. This resulted in only 3 CNAs and a "CNA in Training" for the shift. Concerns regarding resident baths and showers: 1. Review of the 11/29/21 annual MDS	F 725	This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. Corrective Action Director of Business Operations, Facility Administrator, Director of Nursing and Staff Scheduler reviewed the master schedule pattern on 1/31/22 and are placing request for additional agency staffing to provide an adequate number of nursing staff to address the acuity and diagnoses of the facility□s resident population in accordance with the facility assessment, resident census, and daily care required by the residents. We made our needs known to the WHCA and requested National Guard assistance with staffing needs. Identification of Others The Director of Business Operations, Facility Administrator and Director of Nursing revised the Facility Assessment to identify and implement staffing needs for each unit by date of compliance to prevent resident neglect, provide necessary care and services to maintain residents□ hygiene, provide necessary care and services, and provide necessary care and services to provide assist for 2 person transfers for all residents who require it and to provide showers. Systemic Changes Director of Nursing/designee has educated the scheduler, and Licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 725	Continued From page 15 assessment showed resident #79 was admitted to the facility on 1/15/21 with diagnoses which included heart failure, end stage renal disease, chronic obstructive pulmonary disease, anxiety disorder, and depression. The review showed the resident had a BIMS score of 14, which was cognitively intact. The review showed the resident required extensive assistance of 1 staff member for personal hygiene, and transfer assistance of 1 staff member with support for showers and baths. The following concerns were identified: a. Observation on 1/4/22 at 10:11 AM showed resident #79 appeared to have unwashed oily hair. b. Review of the resident's shower documentation showed s/he had received no showers from 12/1/21 to 12/22/21 (20 days), and had most recently received a shower on 12/28/21. c. Interview on 1/6/22 at 3:56 PM with the director of nursing revealed she felt the CNAs failed to document baths and showers consistently. 2. Review of the 9/28/21 annual MDS assessment for resident #10 showed diagnoses which included atrial fibrillation, hypertension, and chronic obstructive pulmonary disease. Further review showed the resident required assistance from 1 staff for personal hygiene and bathing. The following concerns were identified: a. Review of the care plan with a revision date 10/7/21, showed the resident preferred to have 2 showers each week. b. Review of the December 2021 bathing record showed 3 showers were given from 12/1/21 to 12/21/21. 3. Review of the 11/26/21 quarterly MDS	F 725	Nurses prior to the date of compliance on Sufficient Nurse Staffing and the Center Plan to ensure residents receiving assistance of 2 with transfers with Hoyer lifts, and residents who require showers, making sure that they are completed, unless they choose to refuse them by date of compliance. DON/designee and scheduler will review staffing needs 5X a week and provide an adequate number of nursing staff to address the acuity and diagnoses of the facility□s resident population. Monitoring DON and/or designee will audit staffing schedules five times a week for four weeks, then three times a week for four weeks, then two times a week for four weeks to ensure sufficient nursing staffing to meet the daily care required by the residents. NHA and/or designee will review the findings of the audits in the monthly Quality Assurance Performance Improvement Committee meeting for three consecutive months to ensure compliance is achieved and sustained. Subsequent plans of corrections will be implemented as necessary. Date of Complaince 2/9/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 725	Continued From page 16	F 725		

assessment showed resident #77 was admitted to the facility on 5/11/21 with diagnoses which included Alzheimer's dementia, cerebral vascular accident, malnutrition, and depression. The review showed the resident had no BIMS score due to severe cognitive impairment. The review further showed the resident required extensive assistance of 1 staff member for personal hygiene, and 1 staff member assistance for showers and baths. The following concerns were identified:

a. Review of the resident's shower documentation showed s/he received no showers or baths from 12/10/21 through 1/5/22 (26 days).

b. Interview on 1/6/22 at 3:56 PM with the director of nursing revealed her belief the CNAs failed to document baths and showers consistently.

4. Interview with resident #79 on 1/4/22 at 11:06 AM confirmed the facility failed to provide a shower or bath weekly, and s/he stated it was due to inadequate staffing. Review of the resident's shower documentation showed s/he received no showers from 12/1/21 through 12/22/21 (21 days).

Staff and resident interviews, and resident council regarding inadequate staffing:

1. Interview on 1/5/22 at 2:30 PM with CNA #1 and CNA #2 revealed on the days when they had a hall by themselves, they had to transfer the residents using a mechanical lift independently. Both CNAs confirmed they knew it was not safe to transfer with one person, and they needed a second staff member. However, it took a lot of time to try to find someone to help. CNA #2 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 725	Continued From page 17	F 725		

on her hall (Southeast hall) she had 7 residents that required a mechanical lift to transfer, and there was usually only one CNA assigned to that hall. She further stated they were also expected to give baths to the residents. On the days when there's only 1 CNA assigned to a hall the residents didn't get their baths because of the heavy work load.

2. Interview with resident #51 on 1/6/22 at 11:56 AM revealed there was "always" short staffing, "bad weather or not." S/he felt safe with the lift transfers and confirmed there was sometimes just one staff member to operate the lift. The resident then stated, "if they [the facility] had to have 2 [staff] I would never get to bed."

3. Interview on 1/6/22 at 2:17 PM with the DON revealed the facility had nurse position openings for 1 part time day shift and 1 part time evening shift. She stated the expectation was for 2 staff members to transfer the residents who required a mechanical lift. She further stated there was always a nurse available to help the CNAs, they just needed to "hunt them down."

4. Review of the facility's policy titled "Lifting Machine, Using a Mechanical" with a revision date 7/17, showed, "General Guidelines-1. At least two (2) nursing assistants are needed to safely move resident with a mechanical lift..."

5. Review of the 8/25/21 Resident Council Meeting minutes showed the following, "... [DON]-Working to get more staff..." Review of the 9/22/21 Resident Council Officers Meeting showed the following, "...Hiring-Administration continues to use all the tools available to hire new staff, we have also started a Wednesday We

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 725	Continued From page 18 Appreciate You Day for Staff, playing game, food, drinks, and prizes. [Activities] let them know the shortage of staff is everywhere not just here it is throughout our community. Review of the 10/27/21 Resident Council Meeting minutes showed the following, "[DON]-We are working on hiring new staff. The traveling nurses will be rotating in and out. She is starting an Audit for showers again to improve everyone getting a shower..."	F 725		
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 732	Continued From page 19 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the nursing staff postings and staff interview the facility failed to ensure the daily staff posting included the required elements. The census was 83. The findings were: 1. Review of the daily staffing postings from 12/20/21 to 1/5/21 failed to show the following required elements: a. The name of the facility b. The current resident census. c. The total number and the actual hours worked by the registered nurses, licensed practical nurses, and certified nurse aides. 2. Interview on 1/6/22 at 2:20 PM with the DON revealed she was not aware of the requirements for the daily nursing staff postings.	F 732	F732 Posted Nurse Staffing information 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 facility now has the daily nursing staffing posted to include: the facility name, date, total number and actual hours worked of the following categories of licensed and unlicensed nursing staff directly responsible for resident care per	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 732	Continued From page 20	F 732	shift: RN□s, LPN□s, MA-C□s, C.N.A□s and resident census. Identification: Residents currently residing in the facility have the potential to be affected by this deficient practice. Systemic: Human Resource Director will be educated on Posting the Nursing staffing daily and ensuring that all the pertinent information is on the sheets and posted daily at the entrance of the building. The NHA/designee will do random observations to ensure that the daily staffing has been posted correctly on the appropriate form weekly. Monitoring: The NHA/designee will trend any issues identified from his observations to the QAPI Committee monthly x3 to ensure that this process remains in compliance. Date of Complaince 2/9/22	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 757	Continued From page 21 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure medication regimens were free of unnecessary medications related to behavior monitoring for 2 of 6 sample residents reviewed (#6, #23). The findings were: 1. Review of the 9/16/21 quarterly MDS assessment showed resident #6 was admitted to the facility on 8/5/20 with diagnoses that included brain stem stroke syndrome, unspecified dementia without behavioral disturbance, major depressive disorder, and suicidal ideations. Review of current physician orders showed an 8/20/20 order for sertraline (an anti-depressant medication) 100 mg once per day, and a 9/14/21 order for quetiapine fumarate (an antipsychotic medication) 25 mg at bedtime. Further review showed a 3/22/21 order to observe for behaviors and side effects each shift related to the antidepressant medication, and to document observations in the progress notes. Review of the current care plan, last updated 9/22/21, showed the resident " ... has a hx [history] of behavior problem (i.e. yelling, spitting, verbally threatening staff and will become angry at others during activities and storm off yelling) ... [S/he] refuses cares ..." The interventions included, "Administer	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 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: Resident # 6, now has behavior monitoring in place for her anti-depressant and anti-psychotic medication, and these behaviors are reflected on her care plan. Resident #23, now has behavior monitoring in place for her anti-psychotic medication, and these behaviors are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 757	Continued From page 22 medications as ordered. Observe/document for side effects and effectiveness." Further review of the care plan showed the resident received antidepressant medication for his/her depression, and for staff to observe for changes in behavior, mood, cognition, and suicidal ideation. The following concerns were identified: a. Review of a 10/19/21 physician progress note showed the resident's " ... past medical history is significant for a CVA, dementia and mood changes ..." Further review showed " ... Mood is about the same, always a bit volatile ..." b. Review of the current physician orders showed the order for the antidepressant medication sertraline was ordered on 8/20/20. However, the order for behavioral observation was not ordered until 3/22/21. This order did not reflect resident-specific target behaviors. Further review showed there was no order for behavioral observation or monitoring for the antipsychotic medication quetiapine. c. Review of the nursing progress notes for October 2021 through December 2021 showed six separate notes indicating resident behaviors were observed that included anger, verbal aggression, and care refusals. Review of the MAR and TAR for October 2021 through December 2021 showed behavior monitoring observations were to be completed three times per day. Further review showed the documentation indicated a check mark for completion for all but two shifts; however, the documentation did not indicate whether or not behaviors were observed, and if they were, what behaviors were displayed. d. Review of the medical record showed no documentation reflecting interventions, medicinal or non-pharmacological, that were utilized during the times of documented behaviors reflected in	F 757	reflected on her care plan. Identification: Residents currently in the facility have been reviewed by the IDT, to ensure that those who are on psychotropic medication have behavior monitoring in place. Their care plans have been reviewed to make sure that the behaviors are reflected on the care plans. Systemic: Nursing staff will be educated by DON/designee by 2/9/22 on making sure that Residents who have orders for psychotropic medications are being monitored for behaviors related to the reason they are on the medication and that those behaviors are reflected on their care plans. Interdisciplinary Team (IDT) has been educated to ensure that upon their monthly psychotropic review that they are checking for behavior monitoring to being in place on appropriate medications and that the behavior monitoring is specified on the care plans as well. This will be completed by the Director of Clinical Services on 1/31/22. IDT is reviewing admissions for psychotropic to ensure behavior monitoring is in place, and that it is reflected on the care plan. Social Services Consultant will review 10% of residents per month who are on psychotropic to ensure that behavior monitoring is in place and is reflected on the care plan. She will submit her report to the NHA. Monitoring:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 757	Continued From page 23 the progress notes. Further review showed no resident-specific target behaviors were identified or monitored. 2. Review of the 10/15/21 quarterly MDS showed resident #23 was admitted to the facility on 4/19/19, with diagnoses that included cognitive communication deficit and vascular dementia with behavioral disturbance. Review of current physician orders showed a 12/6/21 order for quetiapine fumarate (an antipsychotic medication) 75 mg by mouth three times per day. Review of the current care plan, last updated 10/26/21, showed the resident was physically and verbally aggressive towards others and was resistive to cares. Further review showed the resident received medication for his/her dementia, and for staff to observe for behaviors and side effects of the medication. Staff were to document in the progress notes. The following concerns were identified: a. Review of the nursing progress notes from October 2021 through December 2021 showed 10 notes documenting behavioral observations, including restlessness, anxiety, and the resident stating s/he "... will die before anyone gets here." b. Review of the MAR and TAR for October 2021 through December 2021 showed behavior monitoring observations were to be completed twice per day; however, the completed documentation showed annotations for monitoring side effects of the medication, not resident target behaviors. c. Review of the medical record showed no resident-specific target behaviors were identified or monitored. 3. Interview with the DON on 1/6/22 at 3:26 PM revealed the current orders, along with the	F 757	The Social Services Director will trend the findings of the SSC report and submit it to the QAPI Committee to ensure that any issues can be corrected so that compliance can be maintained. Date of Compliance 2-9-22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 757	Continued From page 24	F 757		

documentation on the MAR/TAR, did not reflect resident-specific target behaviors. She also confirmed the documentation did not show an actual behavior monitoring component to document which behaviors were identified. She stated behaviors were discussed upon admission and during interdisciplinary team (IDT) meetings, and confirmed behaviors may be different between the orders, the care plan, and actual observations, depending on the resident. Her expectation was for staff to document behaviors in the progress notes, and confirmed there were issues with behaviors and interventions reflected in the documentation.

4. Review of facility policy "Behavioral Assessment, Intervention and Monitoring," last revised March 2019, showed "Policy Statement ... 2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment ..." Further review showed "Assessment ... 3. The nursing staff will identify, document, and inform the physician about specific details regarding changes in and individual's mental status, behavior, and cognition ...4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others." Further review showed "Management ... 8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes ... The care plan will include ...a. A description of the behavioral symptoms ... b. Targeted and individualized interventions for behavioral and/or psychosocial symptoms ..." Further review showed "Monitoring ... 1. If the resident is being treated for altered behavior or mood, the IDT will seek and document any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 757	Continued From page 25 improvements or worsening in the individual's behavior, mood, and function ..."	F 757		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on review of quality assurance documentation, staff interview, and review of CMS reports, the facility failed to ensure a quality assessment and assurance (QAA) program was implemented to correct identified quality deficiencies in the area of infection control. The census was 83. The findings were: Review of the facility QAA meeting documentation for the last 12 months showed the facility had meetings monthly with the required committee members. The following concerns were identified: a. Review of the CMS Casper 3 Report with a run date of 12/30/21 showed in the last 4 years the facility was cited with infection control deficiencies on 7/2018, 1/2019, 8/2019, and 7/15/2021. In addition, infection control issues were identified on the current survey of 1/6/22. b. Review of the QAA meeting minutes for the last 12 months showed no specific plan was formulated to address infection control concerns. c. Interview with the administrator on 1/6/22 at 3:21 PM confirmed the facility failed to formulate and implement an effective QAA	F 867	F867 QAPI/QAA Improvement Activities 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: No specific resident was identified in this alleged deficient practice; therefore, no individualized	2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 867	Continued From page 26 program to address the ongoing infection control concerns.	F 867	plan of correction is indicated. Identification: Other residents residing in the community have the potential to be affected by this alleged deficient practice. Systemic: On 2/1/22, the Director of Clinical Operations provided education to on Department Heads on QAPI process and expectations to include reviewing for trends/patterns with implemented systems and process improvement. Plan of correction audits will be reviewed to identify trends and continue to ensure compliance. Identified concerns will have changes made to the plan of correction as indicated. Monthly, NHA/Designee reviews with QAPI committee current quality measure data to analyze facility trends benchmarked against national averages to identify possible performance improvement projects. Monthly, the interim NHA will review Resident Council minutes to obtain information regarding concerns and respond to identified issues. The QAPI team will meet with the Medical Director on a monthly basis and as needed. Monitor: The NHA will chair the QAPI program and ensure all open QAPI problems are reviewed and updated during the monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 867	Continued From page 27	F 867	QAPI meeting. If a QAPI problem requires immediate attention the NHA will call ad hoc meetings of the members. Date of Compliance 2/9/22	
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 28 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedures, the facility failed to ensure transmission-based precautions (TBP) were followed during 1 of 3 observations of	F 880	F880 Infection Control This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Polaris	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 29 hydration pass. This failure resulted in an unacceptable risk to resident health and a determination of immediate jeopardy. In addition, the facility failed to ensure acceptable infection control practices were followed during 5 random observations of hand hygiene and personal protective equipment (PPE) use, 2 random observations of treatments, and 1 random observation of equipment disinfection. The census was 83. The findings were: 1. Continuous observation on 1/3/22 beginning at 12:47 PM showed RA (resident aide) #1 brought the mobile ice cart onto the northeast hall, and parked it across from room 153. The room had signage displaying "Enhanced Airborne Precautions" hanging on the door, indicating gown, gloves, N95 mask, and eye protection were required, and a small cabinet of PPE supplies next to the door. Observation showed the RA wearing an N95 mask, as well as protective eyewear. She then donned an isolation gown, applied gloves, and entered room 153. The following concerns were identified: a. On 1/3/22 at 12:47 PM the RA exited the room carrying the resident's plastic water mug, still wearing all of the PPE. She crossed the hall, set the mug on the mobile ice cart, and returned to room 153 to doff the gown and gloves, disposing of them within the room. She then exited the room, and returned to the mobile ice cart. The N95 mask was not changed, and no hand hygiene was performed after removal of the gown and gloves. She then opened the ice chest, picked up the ice scoop and resident's water mug. She held the mug over the ice chest, and began scooping ice into the mug. The ice scoop was observed making contact with the inside of the water mug. After the last scoop of ice, the cup	F 880	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 facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of 483.80 for the affected unit identified in the deficiency. The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director shall complete the following. 1. Identify and implement hand hygiene procedure, for staff and residents, consistent with current nursing facility guidelines from the centers for disease control (CDC) and Centers for Medicare and Medicaid Services (CMS) For staff providing hydration to residents. 1. Staff will implement appropriate transmission-based precautions when providing hydration to the residents. Identification: The Infection Preventionist, in conjunction with the interdisciplinary team will review current COVID-19 nursing facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 30 appeared too full and had a large chunk of ice on top. The RA used the scoop to remove the ice from the mug, and scraped the contaminated ice back into the ice chest. She re-entered room 153 without performing hand hygiene or donning a gown or gloves, delivered the mug, and exited the room. No hand hygiene was performed upon exit. The aide then left the unit. Continuous observation showed although the RA left the unit, the mobile ice cart remained in the hallway. b. At 1:01 PM RA #1 returned to the unit. She entered room 143 without performing hand hygiene, and exited seconds later with the resident's plastic water mug, with no hand hygiene performed upon exit. She picked up the ice scoop and began filling the mug. The scoop was observed making contact with the inside of the resident's mug. After filling the mug, she then re-entered room 143, delivered the mug, and exited, with no hand hygiene performed upon entry or exit. She then moved the mobile ice cart outside of room 145, retrieved the resident's mug, removed the lid to the mug, and set it on the ice cart. She then filled the mug with ice, with the ice scoop making contact with the inside of the resident's mug. She re-applied the lid and returned the mug to room 145, with no hand hygiene upon entry or exit. The same observations were made while she moved down the hall to supply ice to rooms 146 and 147, contaminating the ice scoop, mugs, and ice cart, with no hand hygiene observed during the process. c. On 1/3/22 at 1:16 PM, the surveyor intervened to stop the hydration pass. Interview with RA #1 at that time revealed she was aware full PPE was required while in rooms on contact precautions, and that she was required to perform hand hygiene when entering and exiting	F 880	guidelines from the CDC and CMS. The IP, DON, and applicable IDT members will evaluate the facility□s overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. Guidelines for Covid-19 can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-html System Changes: All Staff have been educated on the appropriately Passing of Ice and Water to prevent cross-contamination to Residents as well as completing return demonstration. Staff have been educated on what transmission-based precautions means and the importance of donning all appropriate PPE. This education was given during the time of the survey by the IP/Staff Development Coordinator/designee. Newly hired staff will be educated on Transmission based Precautions, donning of PPE when entering room, Facility policy on Hand Hygiene, the Passing of Ice and Water to Residents and they will also complete a return demonstration of hand hygiene. The Facility has contracted an outside consultant who has her Infection Preventionist Certification through CDC to: " Conduct an ICAR with the facility to assess IPC practices r/t to covid-https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-icar-facilitator-guide.pdf .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 31 all rooms. She stated she was a new employee and had started about a week ago. She further confirmed the observed process of passing the ice using the ice chest, scoop, and resident mugs was her normal routine. d. Interview with the IP on 1/6/22 at 10:28 AM revealed staff were expected to change or apply a new N95 mask upon exiting rooms under "Enhanced Airborne Precautions." Further interview revealed she expected staff to use a clean mug for passing ice, but if it was not possible, use methods to prevent the mug from contaminating the ice, scoop, and mobile ice cart " ...since everyone uses it, and more than one resident gets ice out of it." She also confirmed hand hygiene was expected to be performed between resident contact and contact with resident's items, in and out of every resident room each time, before PPE application, and after PPE removal. e. Interview with the IP on 1/6/22 at 2:22 PM revealed she does not always have enough time for infection control tasks, and sometimes only one day a week was dedicated to infection control tasks, as she was pulled to the units to cover medication passes to residents and additional tasks. Review of the surveillance audits at that time showed hand washing audits were performed on 9/13/21 and 10/4/21, a PPE audit was performed on 7/12/21, and mechanical lift cleaning audits were performed on 9/11/21, 9/12/21, 9/13/21, 9/15/21, and 9/17/21. 2. Review of facility policy "Handwashing/Hand Hygiene," last revised August 2015, showed " ... 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors ... 7. Use an	F 880	" Assessing current new hire orientation for quality r/t to IPC and will submit recommendations to be implemented. Her duties going forward will also include assess ongoing training, education and competency practices related to IPC, " Conduct rounds at the facility, observe peri care, hand hygiene during care, and kitchen inspection. On or before the facility shall complete the following actions: On or before 2/9/22 the facility shall complete the following actions: Related to hand hygiene The DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to Failure to ensure hand hygiene was performed before and after contact with a resident. Failure to ensure hand hygiene was performed after contact with blood, body fluids, or visibly contaminated surfaces. Failure to ensure hand hygiene was performed after contact with objects and surfaces in the residents environment. Failure to ensure hand hygiene was performed before donning and after the removal of personal protective equipment. Monitoring: Monitoring of approaches to ensure infection control and prevention are effective will include: Weekly or no less than 12 weeks, the IP, DON and applicable IDT will conduct on-going monitoring via observation to ensure staff are complying with requirements for:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 32 alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ... l. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; ... 8. Hand hygiene is the final step after removing and disposing of personal protective equipment." 3. Review of facility policy "Isolation - Categories of Transmission-Based Precautions," last revised October 2018, showed "Contact Precautions ... 4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room ...b. Gloves will be removed and hand hygiene performed before leaving the room ... 5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed." On 1/3/22 at 5:17 PM the administrator was informed of an immediate jeopardy situation in the area of infection control related to a failure to implement safe infection control practices regarding hand hygiene, donning PPE, and handling of a ice scoop while providing hydration to residents. The facility submitted an action plan which included the following immediate changes: a. All coolers, scoops, and resident water containers were pulled from the Units and Resident rooms. They were taken to the Dishwashing Room and washed/sanitized in dish machine. b. The identified Ice Machine has been emptied and placed out of service until vendor	F 880	Compliance of staff with hand hygiene during resident care. Compliance of staff with hand hygiene before and after the use of PPE. Weekly for no less than 12 weeks, the IP, DON and applicable IDT will conduct on-going monitoring via observation to ensure staff are complying with requirements for: Compliance of staff with appropriate PPE use during resident care. After 12 weeks of monitoring, provided that such monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the QAPI committee and Medical Director Date of compliance 2/9/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 33	F 880		

can come here to clean/sanitize the machine. The sanitized coolers have been filled with ice from the kitchen ice machine and water passed to Residents in sanitized containers.

c. The facility has reviewed the Policies related to the Passing of Ice Water to prevent cross-contamination to Residents. The Facility Administrator, Director of Nursing, and Director of Clinical Operations reviewed the Hand Hygiene Policy and developed a return demonstration for the staff to complete under observation.

d. The Resident Assistant who made the error was educated by the DON/designee on 1/3/2022, on the Facility policy of Passing Ice Water to Residents without causing cross-contamination and when to wash and/or sanitize her hands per guidelines. She was also asked to complete a return demonstration on hand hygiene. In addition, the RA [resident assistant] has been educated on Isolation precautions and the donning of appropriate PPE.

e. All staff are being educated on appropriately Passing Ice and Water to prevent cross-contamination to Residents as well as completing return demonstration. Staff are being educated on what transmission-based precautions means and the importance of donning all appropriate PPE. All staff who have not been able to come back to receive education this night will be educated prior to working their next scheduled shift by the Staff Development Coordinator/designee.

f. Newly hired staff will be educated on Transmission based Precautions, donning of proper PPE when entering a resident room, Facility policy on Hand Hygiene, the Passing of Ice and Water to Residents and will also complete a return demonstration of hand hygiene.

g. DON or designee will do random

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 34	F 880		

monitoring of hand hygiene and passing of ice and water to residents to ensure there is no cross contamination.

The action plan was accepted on 1/4/22 at 9 AM.

The implementation of the action plan was verified and immediacy was removed on 1/4/22 at 5:06 PM; however, deficient practice remained at a scope and severity level of "F."

Concerns related to hand hygiene and use of PPE:

1. Observation on 1/5/22 at 9:56 AM showed room number 117 was posted as an airborne precaution room, and the required PPE listed was: gloves, gown, N95 mask, and goggles. In addition, there was a PPE supply cart located outside the entrance of the room. The following concerns were identified:

a. On 1/5/22 at 9:56 AM LPN #2 was observed exiting the posted transmission based precaution (TBP) room without wearing any goggles or eye protection. Interview at that time with the LPN confirmed she had not worn any eye protection when in the room, she stated there were none available in the PPE cart. Observation at the time of the PPE cart next to the room showed it was stocked with the exception of eye protection.

b. Interview on 1/6/22 at 10:18 AM with the IP verified the nurse should have been wearing eye protection when in the TBP room, and staff knew where to find additional supplies including eye protection

2. Observation on 1/5/22 at 9:59 AM showed RN #1 and social worker #2 were working directly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 35	F 880		

with residents in the therapy department and in the hallway. These staff members wore N95 masks and their personal prescription eyeglasses without additional eye shield or goggles. Interview at that time with social worker #2 revealed they were told this was okay and extra eye protection was not needed. Interview on 1/6/22 at 10:18 AM with the infection preventionist confirmed eye protection was required when working directly with the residents. Prescription eyeglasses need to be covered with a shield or goggles.

3. Observation on 1/3/22 at 11:03 AM showed CNA #2 donned gloves, and performed perineal care for resident #32. The following concerns were identified:

a. After providing perineal care, the CNA continued to wear the contaminated gloves, and touched the resident's brief and clothing, and the sling used for the mechanical lift transfer. The CNA removed the glove on her left hand, and transferred the resident to the wheelchair using the mechanical lift. The CNA then removed the glove on her right hand and changed the resident's shirt. The CNA took the plastic bag with garbage out of the room to the dirty utility closet. Continued observation showed the CNA did not perform hand hygiene.

b. Interview with the CNA at the end of the observation revealed she should have removed her gloves after completing perineal care. She further stated she did not wash her hands after removing the gloves because she did not "feel they were dirty."

c. Interview on 1/6/22 at 10:19 AM with the IP revealed the expectation after performing perineal care was to remove the gloves, perform hand hygiene, then touch clean surfaces. She further stated staff were to perform hand hygiene after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 36	F 880		

completing resident care.

4. Observation on 1/3/22 at 12:57 PM showed CNA #4 exited room 152, which displayed signage showing "Enhanced Airborne Precautions," with no hand hygiene performed upon exit. She had doffed her PPE while in the resident's room, and upon exiting, had a piece of the disposable gown stuck around her waist. The piece then fell to the floor as she walked down the hall, and after noticing, she picked the piece up, wadded it into a ball, and carried it down the hall, throwing it away in a trash can inside the unit nursing station. No hand hygiene was observed, and she left the unit.

5. Observation on 1/5/22 at 9:48 AM showed RN #3 exit room 152, which displayed signage showing "Enhanced Airborne Precautions," The following concerns were identified:

a. As the RN left the room, she continued to wear the PPE and carried un-bagged meal trash into the hallway. She set the trash on top of the PPE supply cart outside of the room, doffed her gown and gloves, wadded them up into a ball. She did not change her N95 mask, bag or contain the trash, or perform hand hygiene upon exiting room 152. She then gathered up the ball of used PPE and trash against her body, and walked down the hall to the soiled utility room. She pressed the pass code to enter the soiled utility room, entered, disposed of the used PPE and trash, and exited the soiled utility room.

b. Interview with RN #3 on 1/5/22 at 9:57 AM revealed she had forgotten to remove her PPE when leaving the room. Further, she stated it was her usual practice to take used PPE and trash from the isolation rooms to the soiled utility room because there wasn't a trash can in the room, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 37	F 880		

it was always full.

6. Interview with the IP on 1/6/22 at 10:28 AM revealed hand hygiene was expected to be performed between resident contact and contact with resident's items, in and out of every resident room each time, before PPE application, and after PPE removal. She stated she expected trash and doffed PPE to remain within the rooms on precautions; if unavoidable, items should be bagged and contained before leaving the isolation rooms.

7. Review of facility policy "Standard Precautions," last revised October 2018, showed "Standard precautions include the following practices: 1. Hand hygiene ... b. Hand hygiene is performed with ABHR [alcohol-based hand rub] or soap and water: ... (3) after contact with items in the resident's room; and (4) after removing PPE."

8. Review of facility policy "Handwashing/Hand Hygiene," last revised August 2015, showed " ... 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors ... 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ... l. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; ... 8. Hand hygiene is the final step after removing and disposing of personal protective equipment."

Concerns related to cross-contamination during treatments:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 38	F 880		

1. Observation on 1/5/22 at 9:53 AM showed LPN #3 brought wound supplies into the room to provide treatment for resident #79. The following concerns were identified:

a. The LPN placed gauze pads, an elastic bandage wrap, two tubes of multi-dose squeezable medicated ointments, and a spray bottle of cleansing solution, all on top of a magazine located on the resident's bedside tray table; The LPN did not ensure the table area was clean prior to placing the supplies. The LPN then performed hand hygiene and donned gloves, and removed the resident's old dressing from his/her right shin area placing it in the trash. Without changing gloves, she cleansed the wound and applied the treatment. The nurse removed her gloves and left the room with the cleansing spray bottle, and the two multi-dose tubes of medication. In the hallway, she then placed the items under her arm while performing hand hygiene.

b. Continued observation showed the LPN removed the items from her under her arm, and placed them in the wound care cart without disinfecting them. Interview with the nurse at that time confirmed no barrier was on the bedside tray table, and the table had not been disinfected. Further, she confirmed the two tubes of medication had not been disinfected before placing them back in the wound care cart.

c. Interview with the IP on 1/6/22 at 10:10 AM revealed her expectation was for the the medications to be put into cups and be disposed of after use, not to take multi-use tubes into a resident's room. Further, she stated there should be a barrier to ensure cleanliness of supplies.

2. Observation on 1/4/22 at 4:40 PM showed RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 39	F 880		

#2 exit room 153, which displayed signage showing "Enhanced Airborne Precautions." She had doffed her PPE while in the room. The following concerns were identified:

a. As the nurse exited she was observed carrying a squeezable tube of medication with bare hands; she did not change her N95 mask upon exit. She placed the tube on top of the medication cart, performed hand hygiene, and turned to talk to other staff members in the hallway. Next, she picked up the tube of medication, placed it in her pocket, and continued to talk to the other staff members. She then turned back to the medication cart, removed her keys that were located in the same pocket as the tube, unlocked the medication cart, and removed the tube from her pocket, placing it in the drawer of the medication cart. No hand hygiene was observed after the medication was placed in the cart.

b. Interview with RN #2 on 1/4/22 at 5:17 PM confirmed there were no decontamination wipes inside the room or in the PPE supply drawers outside of the isolation rooms to wipe items down. However, it was observed at that time a container of bleach wipes was available on top of the medication cart.

c. Interview with the IP on 1/6/22 at 10:28 AM revealed the expectation for staff regarding the squeezable tube of medication was to " ... dispense the medication into a cup and carry that into the room, not take the whole tube in there." She verified the nurse should have taken only enough medication in for the application, and then discarded the cup in the room. She also confirmed the nurse should have decontaminated the tube upon exit, and avoided placing contaminated items into her pockets. She confirmed hand hygiene was expected to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 40	F 880		

performed between resident contact and contact with resident's items, in and out of every resident room each time, before PPE application, and after PPE removal.

Concerns regarding cleaning/disinfection of resident care equipment:

1. Observation on 1/4/22 at 3:01 PM showed CNA #3 coming out of the TBP room 117 with a sit-to-stand lift. The CNA appropriately doffed her PPE and used hand sanitizer. Realizing there were no sanitizing wipes available in the isolation supply cart, she left to locate some. The following concerns were identified:

a. CNA #3 returned with a purple lid container of "Super- Sani-Cloth." She used 1 wipe to disinfect the entire lift starting at the base and working her way to the top. As the CNA conducted the process, the wipe was wadded up and there was no visible wetness to the equipment.

b. Interview with CNA #3 on 1/4/22 at 3:08 PM revealed she knew one type of wipe used by the facility had a 3 minute wet contact time. However, she was unsure of the contact time required for the wipe she used, and she had not checked to see if the lift remained wet for any amount of time.

c. Interview with the IP and CNA #3 on 1/4/22 at 3:26 PM revealed they had discussed the wipes used to sanitize the lift, and the purple lid container required a 2 minute wet contact time. The lift was going to be re-wiped to ensure the proper contact time was achieved. The IP confirmed the wipes needed to be used in a way to ensure the item/lift was sufficiently wet to ensure the required contact time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 880	Continued From page 41 2. Review of facility policy "Cleaning and Disinfection of Environmental Surfaces," last revised June 2009, showed " ... 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled."	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of infection control documentation, and policy review, the facility failed to ensure an antibiotic stewardship program was implemented, which affected 1 of 1 sample resident (#77) reviewed for antibiotic orders and administration. The findings were: 1. Review of the 11/26/21 quarterly MDS assessment showed resident #77 was admitted to the facility on 9/14/21 with diagnoses which included Alzheimer's disease, depression, and malnutrition. Review of the physician orders showed Macrodantin 50 mg (an antibiotic medication) was ordered by mouth daily on 12/21/21 with no end date. Review of December 2021 and January 2022 medication	F 881	F881 Antibiotic Stewardship 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	2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	01/06/2022

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
F 881	Continued From page 42 administration records showed the medication was administered daily as ordered. 2. Review of facility infection control program documentation showed no identification of residents with orders for antibiotics without an end date to the order. Interview with the IP on 1/6/22 at 2:22 PM revealed she did not have enough time for infection control tasks, and sometimes she devoted only one day a week to infection control because she was pulled to the units to pass medications to residents and perform other tasks. She stated that no rationale was documented by the physician for the resident to receive the Macrodantin antibiotic without an end date. 3. Review of the policy titled, "Antibiotic Stewardship" last revised December 2016 showed as a Policy Statement, "Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program." The following was documented under "Policy Interpretation and Implementation," "...4. If an antibiotic is indicated, prescibers will provide complete antibiotic orders including the following elements...d. Duration of treatment: (1) Start and stop date; or (2) Number of days of therapy..."	F 881	compliance with federal Medicare and Medicaid requirements Correction: Resident #77, antibiotic use was reviewed with Dr. Dobson who discontinued the medication on 1/17/22. Identification: Residents currently residing in the facility have been reviewed to ensure that those on antibiotics are appropriate. Systemic: Infection Preventionist has been educated by the DON/designee on 1/31/22, completing the Antibiotic Timeout form on any resident who has an antibiotic started or is admitted with to determine whether it meets the McGreer Criteria. Interdisciplinary Team reviews the 24-hour report for new orders during the morning clinical meeting for any Residents with who were started on antibiotics. They will make sure that the IP is made aware so that if the Antibiotic Timeout form has not been completed it will be completed at that time to make sure that it is being given appropriately. If not, the MD will be notified at that time for a review. Monitoring: The IP will report on the Antibiotic usage in the facility and the completion of the Antibiotic Timeout Form and whether it meets criteria. This report will be given to the QAPI Committee monthly to ensure compliance is maintained. Date of Compliance 2/9/22	