STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 07/01/2020 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 A licensure survey was conducted by Healthcare Licensing and Surveys from 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.	S 000		
S2917	Ch 11 Sec 6 (b)(i) Physical Environment (b) Sanitary Environment. The Nursing Care Facility shall establish policies and procedures for investigating, controlling and preventing infections.	S2917		2/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 1 (i) Policies, procedures, and techniques shall be regularly reviewed, particularly those concerning food service, laundry practices, and the disposal of environmental and resident wastes. This State Rule and Regulation 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 hydration pass. 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,	S2917	S2917 Physical Environment 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 2	S2917		

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 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,

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 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

Systemic:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 3	S2917		

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 while entering and exiting 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,

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 .

" 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 4 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 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." 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:	S2917	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: 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 5 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 that 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 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 needed to be covered with a shield or goggles. 3. Observation on 1/3/22 at 11:03 AM showed CNA #2 donned gloves, and perform 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 briefts 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	S2917	Date of Compliance: 2/9/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 6	S2917		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 7 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 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	S2917		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 8	S2917		

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:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 9	S2917		

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 #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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 10	S2917		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTE	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) COMPLETE DATE
S2917	Continued From page 11 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 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."	S2917		