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 _____	07/01/2022

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 6/27/22 to 7/1/22.	S 000		
S2919	Ch 11 Sec 6 (b)(iii) Physical Environment (b) Sanitary Environment. The Nursing Care Facility shall establish policies and procedures for investigating, controlling and preventing infections. (iii) The facility shall report the required diseases/conditions to the Wyoming Department of Health, Epidemiology Unit as per W.S. §35-4-107. In addition, those conditions classified as nosocomial where two (2) or more persons, either residents or employees, are affected shall be reported immediately to the State Health Officer, the County Health Officer, and the Licensing Division. The Nursing Care Facility Administrator or his/her designated representative shall furnish all available pertinent information related to such disease or condition to the Licensing Division. This State Rule and Regulation is not met as evidenced by: Based on review of facility reportable incidents, staff interview, review of the facility's COVID line list, and policy review, the facility failed to ensure infectious disease outbreaks were reported as required. The resident census was 60. The	S2919	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	7/26/22

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S2919	Continued From page 1 findings were: 1. Review of the facility's line list of COVID-19 positive residents and staff, provided by the facility at the time of entrance, showed resident #63 tested positive for COVID-19 on 5/24/22, cook #2 tested positive on 6/7/22, resident #57 tested positive on 6/18/22, the business office manager tested positive on 6/24/22, and CNA #5 tested positive on 6/24/22. 2. Review of the facility's reported incidents from 5/1/22 to 7/1/22 showed no evidence the facility reported an infectious disease outbreak to the state survey agency or state epidemiology. 3. Interview with the DON and clinical consultant on 7/1/22 at 11:24 AM revealed positive COVID-19 results were to be reported to the state as an outbreak and confirmed they were not reporting single cases of positive COVID-19 results and did not report any cases identified in May or June 2022. 4. Review of the policy titled "Coronavirus Disease (COVID-19)-Testing Residents" last revised August 2020 showed "...8. The infection preventionist, or designee reports positive test results to the local or state health department (as appropriate) for contact tracing and to the CDC National Health and Safety Network (NHSN)."	S2919	Resident #63 was reported to the state as being Covid positive on 7-26-22. Cook #2 was reported to the state as being Covid positive on 7-26-22. Resident #57 was reported to the state as being Covid positive on 6-20-22. BOD was reported to the state as being Covid positive on 7-26-22. CNA #5 was reported to the state as being Covid positive on 7-26-22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: NHA and IP/Designee were educated by the DON that Covid positive staff and residents must be reported to the state survey agency, state epidemiology, NHSN, and CDC on 7-25-22. NHA or IP should report to the state survey agency within 24 hours of positive notification. NHA or IP should report to the state epidemiology and CDC within 1 week of positive notification. NHA or IP should report to the NHSN every Monday prior to 12:00 am/EST of positive notification. Weekly for no less than 12 weeks, the IP, DON and applicable IDT will conduct on-going monitoring via observation and	

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S2919	Continued From page 2	S2919	line listing audits to ensure staff are complying with requirements for. b. Screening, identification and reporting of infectious disease outbreaks. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The IP/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The IP will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits. After 12 weeks of 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 QAPI 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.	