| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 535025 | A. BUILDING _____ B. WING _____ | C 01/19/2024 |

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

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| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare Licensing and Surveys from 1/17/24 to 1/19/24. The survey was prompted by complaint intakes WY00003768, WY00003767, WY00003764, and WY00003758.<br><br>The following common abbreviations are used throughout this document:<br>ADLs: Activities of Daily Living<br>BIMS: Brief Interview for Mental Status<br>CNA: Certified Nursing Assistant<br>DON: Director of Nursing<br>LPN: Licensed Practical Nurse<br>NHA: Nursing Home Administrator<br>RN: Registered Nurse<br>AROM: Active Range of Motion<br>PROM: Passive Range of Motion<br>HR: Human Resource<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, resident representative and staff interview, facility policy and procedure review, and review of facility | F 689 | Past noncompliance: no plan of correction required. | |

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

Electronically Signed | 03/14/2024

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| F 689 | Continued From page 1 | F 689 | | |

corrective action documentation, the facility failed to prevent an avoidable accident for 1 of 3 sample residents (#2) reviewed for accidents. This failure resulted in past non-compliance for resident #2 who had a fall as a result of staff error. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 12/21/23. The findings were:

1. Review of the "Nursing Admission Data Collection" for resident #2 showed the resident was admitted to the facility on 12/11/23 for rehabilitation due to a right hip fracture, Further review showed a summary "AROM and PROM limited on right side due to pain and weakness from surgery. Currently toe touch weight bearing on right leg." Review of the "Transfer Evaluation" dated 12/11/23 showed the resident was "Currently toe touch weight bearing on right." The transfer evaluation scored the resident at "9," which indicated the resident which indicated the resident should be transferred with a mechanical lift (total body or stand assist as appropriate). The following concerns were identified:

a. Review of the baseline care plan dated 12/13/23 showed it was incomplete and failed to identify how to transfer the resident and with how many staff.

b. Review of the nurse progress note created on 12/16/23 at 12:15 PM showed "CNA in to assist with toileting, CNA thought resident was one assist d/t miscommunication about transfer status. Resident was standing in front of toilet when aid [sic] was assisting with cleaning [him/her] when resident's legs gave out and resident fell on floor. Resident was assessed for injuries, no injuries noted... Resident has only minor c/o pain at this time."

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| F 689 | Continued From page 2 | F 689 | | |

c. Review of the 12/16/23 risk management report showed "CNA in to assist with toileting, CNA thought resident was one assist d/t [due to] miscommunication about transfer status. Resident was standing in front of toilet when aid [sic] was assisting with cleaning [him/her] when resident's legs gave out and resident fell on floor. Resident was assessed for injuries, no injuries noted."

d. Interview on 1/18/24 at 3:45 PM with CNA #1 revealed s/he used the "report sheet" to gather information on how to transfer resident #2 and confirmed a sit to stand machine or mechanical lift was not used to transfer the resident, and three staff members lifted the resident off of the floor. Furthermore, the CNA stated s/he was not aware of a "Kardex" in the resident chart or how to find the correct information.

e. Interview on 1/18/24 at 12:05 PM with resident #4's representative revealed they were informed by a nurse the resident had fallen due to the CNA not using the appropriate transfer method identified in the resident's care plan.

2. Interview on 1/19/24 at 12:30 PM with the NHA revealed nursing staff were expected to use the mechanical lifts and transfer residents according to the care plans and Kardex.

3. Review of the policy titled "Safe Resident Handling/Transfers" last revised on 1/18/24 showed "Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury ...10. Two staff members must be utilized when transferring residents with a mechanical lift. 11. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as

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| F 689 | Continued From page 3<br>the need arises or changes in equipment occur. 12. The staff must demonstrate competency in the use of mechanical lifts prior to use and ...13. Staff members are expected to maintain compliance with safe handling/transfer practices ...14. Resident lifting and transferring will be performed according to the resident's individual plan of care."<br><br>4. Review of the facility ' s documentation of corrective action for the fall due to improper transfer technique showed the actions taken by the facility included the following:<br>a. The CNA was suspended on 12/18/23 and has not been allowed to provide direct resident care since the incident.<br>b. Management team reviewed and investigated the incident that occurred on 12/16/23 and was educated on change of shift information and proper transfer status.<br>c. Education was provided to nursing staff on proper transfer status and where to find current transfer information on 12/21/23.<br>d. Report sheets were removed and updated accordingly.<br>e. Audits were started on 12/20/23 on lift monitoring and technique. | F 689 | | |
| F 806 SS=D | Resident Allergies, Preferences, Substitutes<br>CFR(s): 483.60(d)(4)(5)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;<br><br>§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat | F 806 | | 1/22/24 |

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| F 806 | Continued From page 4<br>food that is initially served or who request a different meal choice;<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, staff and resident representative interview, and facility policy and procedure review, the facility failed to ensure residents were offered choices during meal times for 1 out of 6 (#4) sample residents related to resident rights. The findings were:<br><br>1. Review of the care plan last revised 1/16/24 for resident #4 showed interventions of: offer preferred foods, "HELP resident #4 with choices as needed. S/he may need only a few options to avoid overwhelming him/her". Review of the 11/30/23 Brief Interview for Mental Status (BIMS) showed the resident had a score of 5 out of 15 indicating severe cognitive impairment. Review of the CNA charting for how the resident eats and drinks showed the resident needed "Oversight, encouragement or cueing" from 12/19/23 to 1/17/24. Review of the meal preference ticket for resident #4 showed "Salt, pepper each tray, and condiments with burgers.... Mightyshake ...at each meal... Add milk to Oatmeal. Salt/Pepper with all meals." The following concerns were identified:<br>a. Observation on 1/17/24 at 4:25 PM showed customer service representative #1 served resident #4 a pulled pork sandwich, beans, and coleslaw, but failed to provide or offer salt, pepper, condiments, or a mighty shake. Interview with therapist #17 at that time confirmed the resident did not have salt or pepper provided or offered with the meal.<br>b. Observation on 1/18/24 at 7:55 AM showed resident #4 was served eggs, dry toast, mighty | F 806 | F806<br>PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL<br><br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br>Resident # 4 plan of care and meal ticket was reviewed. No change was indicated. No other residents were identified.<br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE | |

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| F 806 | Continued From page 5<br>shake, oatmeal, and coffee by the NHA. However staff failed to add milk to resident #4's oatmeal and no salt or pepper was offered as marked on the meal ticket.<br>c. Interview with customer service representative #1 on 1/17/24 at 12:00 PM revealed resident preferences were listed on the meal ticket and prepared for by the kitchen staff and should be honored.<br>d. Interview on 1/17/24 at 2:02 PM with the dietary manager revealed staff should provide resident requests and preferences that were listed on the meal ticket.<br>e. Interview on 1/18/24 at 4 PM with resident #4's representative revealed a concern and had witnessed on 12/2/23 the facility was not offering or providing salt, pepper or ketchup to several residents including a resident with very poor memory that preferred salt and pepper with each meal.<br>f. Interview with the NHA and HR manager on 1/19/24 at 12:30 PM revealed the facility expectation was for staff to offer choices which included salt, pepper and ketchup.<br><br>2. Review of the 1/1/24 "Dining Room Protocol" showed "d. staff will provide condiments as requested by resident or meal ticket preference." | F 806 | SAME DEFICIENT PRACTICE:<br>All residents with specific requests or preferences are at risk due to this alleged deficient practice.<br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br>All staff who assist with meal service/tray delivery were educated by NHA/Designee on resident preferences on meal tickets. Education completed on 1/19/2024.<br>IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br>DM/Designee will audit 5 meal trays per week across all 3 meals weekly x 4 weeks, then monthly for 2 additional months to ensure residents preferences are honored.<br>The DM/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.<br>The DM/Designee will be responsible for following up on any recommendations made by the QAPI Committee.<br>Compliance date: 01/22/2024 | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2) | F 812 | | 1/22/24 |

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| F 812 | Continued From page 6<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility policy and procedure review, and review of the Food Code, the facility failed to ensure staff used beard restraints in accordance with professional standards during 1 of 3 meals. The facility census was 74. The findings were:<br><br>1. Observation on 1/17/24 at 11:50 AM showed cook #1, in the kitchen serving window, standing in the food distribution area, and dispensing resident meals on plates wearing a hat on his/her head, gloves and a long sleeve shirt. Further observation showed resident #4 received a meal at 12:01 PM. The following concerns were identified:<br>a. Observation on 1/17/24 at 11:50 AM showed cook #1 had a short beard, but was not wearing a beard restraint. | F 812 | F812<br><br>PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF | |

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| F 812 | Continued From page 7<br>b. Interview on 1/17/24 at 12:05 PM with the HR Director confirmed staff members were expected to wear a beard restraint and hair nets when distributing food to residents.<br>c. Interview on 1/17/24 at 2:02 PM with the dietary manager revealed cook #1 should have worn a beard restraint.<br>d. Interview on 1/18/24 at 4 PM with resident #4's representative revealed a concern and had witnessed kitchen staff not wearing appropriate hair restraints on 12/15/23 while distributing resident meals.<br>e. Interview on 1/19/24 at 12:30 PM with the NHA confirmed staff were expected to wear beard restraints and hair nets around food and when preparing food in the kitchen.<br><br>2. Review of the facility policy titled "Maintaining a Sanitary Tray Line" last revised 1/18/24 showed "3. During tray assembly, staff shall...h. Wear hair restraints (bonnets, caps, nets, to cover hair) when preparing or handling food."<br><br>3. Review of the 2022 FDA Food Code showed "2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." | F 812 | PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.<br><br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br>Resident # 4 was reviewed with no concerns identified due to meal service completed by employee not wearing beard restraint.<br>No other residents were identified.<br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br>All residents are at risk due to alleged deficient practice.<br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br>All dietary staff were educated on 1/19/24 by NHA/Designee on ensuring staff using beard restraints during meal service and while in the kitchen area.<br>IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br>DM/Designee will complete meal service and kitchen area observations 3 times per week for 4 weeks, then once a week monthly for 8 more weeks to ensure beard | |

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| F 812 | Continued From page 8 | F 812 | restraints are in place.<br>The DM/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.<br>The DM/Designee will be responsible for following up on any recommendations made by the QAPI Committee.<br>Compliance date: 01/22/2024 | |