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 _____	C 10/24/2024

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 10/23/24 to 10/24/24. The survey was prompted by complaint intakes WY00003932, WY00003982, WY00003992, WY00004006, and WY00004007. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		11/15/24

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

Electronically Signed | 11/15/2024

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F 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and resident representative interview, the facility failed to have a system in place to ensure changes in health care appointments were communicated to the resident or the resident's representative for 2 of 4 residents (#1, #8) reviewed for post-hospitalization follow-up appointments. The findings were: 1. Interview with resident #1's representative on 10/24/24 at 10:53 AM revealed the resident was admitted to the facility on 3/22/24 from an out-of-state acute care hospital. Following discharge, the resident had an appointment with a urologist scheduled for 4/1/24 (Monday). The resident's representative revealed she had confirmed the appointment with the resident's nurse the weekend before the appointment and an arrangement had been made for a family member to meet the resident at the appointment; however, when the family member arrived for the follow-up appointment, she was told the appointment had been rescheduled by the facility for "patient convenience" to 4/4/24. Review of the "Discharge Plan of Care", dated 3/22/24, confirmed an appointment had been scheduled with an out-of-state urologist on 4/1/24 at 10 AM.	F 561	F561 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. I. Corrective Action for Residents Affected by Deficient Practice: Residents #1 and #8 are no longer living	

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F 561	Continued From page 2 The following concerns were identified: a. Interview with the director of social services on 10/23/24 at 2:58 PM revealed she did not have any documentation related to the change of the resident's appointment. b. Interview with receptionist #1 on 10/23/24 at 3:02 PM revealed she had a computer program which she used to keep track of resident appointments; however, if an appointment was canceled, she would delete it from the calendar. This was done so the appointment schedule for the day was current for the transportation staff. Review of the April 2024 calendar, with the receptionist, showed no appointments were scheduled for the resident. c. Review of the resident's medical record showed no documentation the appointment had been rescheduled. 2. Review of the "Discharge Plan of Care" for resident #8 showed the resident had a follow-up appointment scheduled for 10/18/24. The following concerns were identified: a. Review of the October 2024 appointment calendar with receptionist #1, showed no evidence of an appointment for the resident. Interview with the receptionist on 10/24/24 at 9:40 AM revealed she had called the provider's office and the provider stated a medical assistant from their office had canceled the appointment; however, the appointment was not rescheduled. b. Review of the resident's medical record showed no documentation the appointment had been canceled. 3. Interview with the director of social services on 10/24/24 at 8:28 AM revealed changes in resident appointments were handled by the DON and receptionist #1.	F 561	in the facility. II. Identification of Other Residents Potentially Affected by the Same Deficient Practice: On November 14, 2024, the Director of Nursing, Social Services Director, and receptionist conducted an audit of admissions from the past month. This was done to ensure that follow-up appointments were scheduled and completed, and to arrange any new appointments as necessary. The Interdisciplinary Team reviewed the Locations, Resources, and Event Types on the PCC calendar, making updates as needed. A Physician Visit Form is being implemented to improve communication between the facility and off-site providers. III. Measures and Systemic Changes to Prevent Recurrence of the Deficient Practice: On November 12, the Staff Development Coordinator and Director of Nursing began staff education on reviewing new admissions and ordering any required follow-up appointments, in accordance with the Provision of Physician Services and Consulting Physician/Practitioner Orders Policies. Staff members were also instructed to inform residents or their representatives about any scheduled appointments or changes to existing appointments. This processed will be a continuous process to ensure the improvement of communication between the facility and off-site providers. IV. Monitoring Performance to Ensure Sustained Solutions: New admissions will be reviewed during	

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F 561	Continued From page 3 4. Interview with the DON on 10/24/24 at 11:31 AM revealed she was unaware of how the change in appointment times were communicated.	F 561	daily meetings to confirm that follow-up appointments have been ordered. Audits will occur weekly for four weeks, then every two weeks for an additional four weeks, and finally monthly for three months. These audits will be conducted by the Director of Nursing or a designated representative, with results reviewed during Quality Assurance Performance Improvement meetings. Compliance Date: December 2, 2024.	
F 880 SS=F	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 §483.71 and following accepted national standards;	F 880		11/15/24

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F 880	Continued From page 4 §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; (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.	F 880		

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F 880	Continued From page 5 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 review of the facility's COVID-19 infection control outbreak records, staff interview, and policy and procedure review, the facility failed to ensure a system was in place for documenting resident and staff SARS-CoV-2 test results during an outbreak. The census was 81. The findings were: 1. Review of the facility's COVID-19 infection control outbreak records showed one staff member tested positive for SARS-CoV-2 on 9/12/24 and another on 9/13/24. Further review showed residents were tested on 9/12/24, 9/17/24, 9/20/24, 9/23/24, 9/26/24, 10/1/24, 10/4/24, and 10/7/24. One resident tested positive on 9/20/24, one resident on 9/23/24, two residents on 10/1/24, and three residents on 10/4/24 (7 total). Further review of the facility's documentation showed staff were screened for symptoms and tested from 9/13/24 through 10/7/24. Two staff members tested positive on 9/26/24. There was no further documentation available. 2. Telephone interview with the former infection preventionist on 10/24/24 at 9:35 AM revealed she had resigned her position on 10/9/24 and had not been in the facility since that date. 3. Interview with the NHA on 10/24/24 at 10:25 AM confirmed there was no documentation of the testing done after 10/7/24; however, the screening and testing of residents and staff was completed and discussed during their morning meetings. The NHA provided documentation from	F 880	F880 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. I. Corrective Action for Residents Affected by the Deficient Practice: Currently, there are no residents or staff members in the building with a positive COVID-19 test. II. Identification of Other Residents Potentially Affected by the Same Deficient Practice: Currently, there are no residents or staff members in the building with a positive COVID-19 test. However, all residents	

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F 880	Continued From page 6 the morning meeting minutes which showed on 10/9/24 the facility had two residents and one staff member with unresolved cases of COVID-19. The documentation showed no further positive test results. 4. Interview with RN #1 on 10/24/24 at 10:47 AM revealed she had tested CNA #1 on 10/10/24, due to the CNA showing symptoms, and again on 10/16/24; however, she had not documented the results. 5. Interview with RN #2 on 10/24/24 at 10:48 AM revealed she had tested CNA #1 on 10/18/24; however, she had not documented the results. 6. Telephone interview with RN #3 on 10/24/24 at 12:09 PM revealed the former infection preventionist had instructed her to test residents and staff every 3 days until the outbreak was resolved. RN #3 confirmed she had performed the testing, as instructed, and all tests were negative; however, she had not documented the results. 7. Interview with the NHA on 10/24/24 at 11:35 AM revealed he determined the outbreak was resolved on 10/22/24. 8. Review of the facility's "Covid Guidelines Outbreak Status" showed "...Staff and residents must test twice a week until there are no new cases for 14 days...OUTBREAK STATUS IS OVER 14 DAYS AFTER THE LAST COVID POSITIVE TEST".	F 880	and staff members are at risk for potential COVID-19 exposure. Standard and Transmission Precautions are in place as needed for residents and staff. An audit for COVID-19 status among residents and staff was conducted on November 13, 2024, by the Infection Control Nurse, and the outcome was negative. The Director of Nursing and relevant providers were notified of the results on the same date. II. Measures and Systemic Changes to Prevent Recurrence of the Deficient Practice: Staff education took place on November 12 and 13, 2024 and will continue until all staff members are educated by December 2, 2024. The Executive Director has formulated and trained the Director of Nursing (DON) and the Infection Control Preventionist in the process for documenting COVID-19 results. Training will be conducted by the Infection Control Nurse and the Director of Nursing on proper COVID-19 documentation. A Progress Note (Point Click Care) will be created to document the results of COVID-19 testing in each resident's medical record at the time of testing. All staff members will complete a testing form to record their results, which will be verified by a nurse. The Infection Control Nurse or a designated individual will maintain a list of these test results. IV. Plans for Monitoring Performance to Ensure Solutions are Sustained: We will conduct audits of COVID-19 testing for residents and staff on a weekly basis following any positive result for four weeks, followed by monthly audits for the	

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F 880	Continued From page 7	F 880	next three months. These audits will be carried out by the Director of Nursing or a designated person, with results reviewed during the Quality Assurance Performance Improvement meetings for the next ninety days. Compliance Date: December 2, 2024.	