

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Polaris Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12th Street Cheyenne, WY 82001	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220</p> <p>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:</p> <p>1. Interview with resident #1's representative on 10/24/24 at 10:53 AM revealed the resident was admitted to the facility on [DATE] 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. The following concerns were identified:</p> <p>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.</p> <p>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.</p> <p>c. Review of the resident's medical record showed no documentation the appointment had been rescheduled.</p> <p>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:</p> <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Polaris Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12th Street Cheyenne, WY 82001	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. Review of the resident's medical record showed no documentation the appointment had been canceled.</p> <p>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.</p> <p>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.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Polaris Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12th Street Cheyenne, WY 82001	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220</p> <p>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:</p> <ol style="list-style-type: none"> 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 [DATE], 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 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. 		