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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Rehabilitation and Care Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, facility investigation notes review, and policy and procedure review the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 2 sample residents (#4) reviewed with abuse allegations. The finding were: 1. Review of the annual MDS assessment dated [DATE] showed resident #4 had a BIMS score of 7 out of 15, which indicated severe cognitive impairment, and had diagnoses which included alcohol dependence with withdrawal, anxiety disorder, depression, and psychotic disorder. Review of the quarterly MDS assessment dated [DATE] showed resident #5 had a BIMS score of 11 out 12, which indicated moderate cognitive impairment, and had diagnoses which included anxiety disorder, and depression. The following concerns were identified:a. Review of a facility incident report dated 4/1/25 and timed 12:48 PM showed a witness entered the room of resident #4 and resident #5 and found resident #5 gripping resident #4's arm while saying you killed those three people; now I am going to kill you! Staff intervened by removing resident #4's arm from resident #5's grip and escorting resident #5 out of the room. Resident #5 continued to attempt to re-enter the room stating s/he was going to kill resident #4 as resident #5 claimed resident #4 had murdered three people. After being separated, the facility contacted the provider, who assessed the residents, and identified mild redness to resident #4's arm where resident #5 had grasped it. The incident report showed the facility contacted law enforcement, administered as needed medication to resident #5, moved resident #5 to a different room, performed labs on resident #5 which indicted a positive urinary tract infection, and arranged for psychological evaluations for resident #5. Further review showed when the facility interviewed resident #4 about the incident, the resident stated s/he was fine, described resident #5 as crazy, and requested a private room.b. Review of a progress note for resident #5 dated 4/1/25 and timed 6:45 PM showed Behavior Note Text: Summary of behaviors observed by this nurse after being called to assist with this resident d/t [due to] altercation where it was reported [s/he] was observed attacking [his\her] roommate. Per interview of the staff witness: [S/he] was walking by, and heard [resident name] voice, looked into the room, and observed [resident #5] with one hand holding [his/her] roommate's L [left] arm, other arm raised towards the roommate's head/neck area. The staff member stated she immediately entered the room, and told [resident name] to stop. [Residents' name] replied ‘no!' and the roommate stated help. [Resident's name] refused to let go of the roommate's arm, but did lower [his/her] raised arm, while stating: ‘I can't believe what [s\he] did, I have to take care of this!' The staff member reports that [resident name] continued speaking, but they were attempting to get [resident name] to let go of the roommate's arm, and are not entirely clear what [s/he] stated during that time, as they were interrupting, asking [resident name] repeatedly to let go, and finally had to slide their hand between [residents' name] grip and the roommate's arm to get [him/her] to let go. When this nurse arrived to follow up on the request for assistance, [Residents' name] was at the nurses' station with a different staff member, who was trying to redirect [him/her] as this nurse heard [resident name] state: I am gonna take care of [him/her]! I saw [him/her] kill those 3 kids, and now [s/he] is after the pastor! I am gonna make sure [s/he] is dead, too, so nobody else can get hurt. It's OK if I do this, what are they gonna do to me? They can't put me in jail, I am an old [gender]! This author directed another staff member to block [residents' name] visual line of site to the roommate, and also stepped between that line of site, while asking [resident name] what had happened. [Resident name] stated [S/he's] a murderer! [S/he] killed those 3 kids, I know [s/he] did. It was horrible. And the pastor, I know [s/he] must have killed him too. I have to do something about this. [Resident name] stated the above, 3 times, and when asked when the event she witnessed occurred, she initially stated just now. She then referred back to her concern about the pastor, and that she was worried about them having also been murdered. Once in the new area, [Resident name] returned to [his/her] statements of concerns regarding the pastor. At this time, [name] NP came to check on [resident name], and began interviewing her. NP [name] ordered this nurse to call for labs, to evaluate for possibility of infection, as first step to evaluate if the cause of [his/her] confusion and hallucinations at this time. called [initials] lab for a phlebotomist to draw and transport labs, and then followed up on obtaining a different room for [resident name], so [s/he] would be separated from the roommate. Upon follow up with [resident name] later, after [his/her] blood draw was completed, and she was settled in the new room, the police officers left. The NP [name] approached this nurse to administer a 1-time order for IM antibiotic injection due to elevated white count, and concern for UTI. Nursing staff advised to keep frequent checks on

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, medication variance report review, and policy and procedure review, the facility failed to ensure residents were free of significant medication errors for 1 of 7 sample residents (#2) reviewed for medication errors. This failure resulted in actual harm to resident #2 who was hospitalized in the intensive care unit. The findings were: 1.Review of the quarterly MDS assessment dated [DATE] showed resident #2 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and diagnoses which included renal insufficiency, renal failure, or end0stage renal disease, diabetes mellitus, depression, other toxic encephalopathy, chronic pain syndrome, acquired absence of right leg below the knee, idiopathic gout, and paraneoplastic neuromyopathy and neuropathy. Further review showed the resident experienced pain frequently and reported a pain score of 8 out 10. Review of the physician orders showed the resident received fentanyl (opioid) transdermal patch 72-hour 12 mcg (microgram)/hr (hour) once every 3 days for pain ordered on 12/24/25 and morphine sulfate (opioid) ER (extended release) 30 mg (milligram) by mouth two times per day for pain ordered on 1/16/25. Review of the resident's care plan, initiated on 4/14/21 showed [Resident name] has an ADL self-care performance deficit and needs assistance with self-care tasks to include bathing, transfers, personal hygiene tasks, bed mobility, dressing, eating, toilet use, and locomotion related to impaired mobility, pain, activity intolerance. The following concerns were identified:a. Review of the medication administration record (MAR) for January 2025 showed the resident received the fentanyl patch on 1/18/25 and received the morphine sulfate in the evening on 1/16/25 then in the morning and evening on 1/17/25, 1/18/25, and 1/19/25. b. Review of a Medication Variance Report dated 1/18/25 and timed 12:45 PM showed due to application of new fentanyl patch and old fentanyl not removed. Further review showed the outcome was a change in the resident's level of consciousness and hospitalization.c. Interview with RN #2 on 8/7/25 at 9:18 AM revealed she was on duty for day shift on 1/18/25 and she did not remove the old fentanyl patch when she applied the new one because she did not see it. Further interview revealed she did not document that she had not removed the old patch. d. Interview with RN #3 on 8/7/25 at 8:36 AM revealed she was the nurse who performed the assessment of the resident prior to the hospital transfer. She revealed the resident had a decrease in his/her level of consciousness on 1/20/25. e. Review of the hospital discharge documentation provided by the facility administrator on 8/7/25 at 10:50 AM showed the resident admitted to hospital on [DATE] and returned to the facility on 1/24/25. The documentation showed Discharge Diagnosis: Principal Problem (Resolved): Opiate overdose, accidental or unintentional. Further review showed the resident was admitted to intensive care unit secondary to narcotic overdose and was started on Narcan (opioid antagonist) via intravenous therapy. 2. Review of the policy titled Controlled Substances provided by the DON on 8/6/25 at 12:29 PM showed .The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II - V of the Comprehensive Drug Abuse Prevention and Control Act of 1976).