

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/21/2025
Form Approved OMB
No. 0938-0391

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 08/28/2025
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, medical record review, resident grievance review, and policy and procedure review, the facility failed to ensure routine bathing was provided for 5 of 10 sample residents (#1, #2, #3, #4, #6) reviewed for activities of daily living. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #2 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included morbid obesity, acute respiratory failure, and disorder of skin and subcutaneous tissue. Further review showed the resident had bilateral lower extremity impairment and required partial/moderate assistance with personal hygiene and substantial/maximal assistance with bathing/showering. The following concerns were identified: a. Interview with the resident on 8/28/25 at 11:52 AM revealed the facility did not have enough staff and call lights could take between 15 and 30 minutes to be answered. The resident revealed s/he did not receive bathing regularly and prior to 8/26/25, the last shower s/he received was while s/he was in the hospital. Further interview revealed s/he had to contact the director to get the bed bath s/he received on 8/26/25. b. Review of a Concern Form dated 8/26/25 showed the resident reported s/he had not received a bed bath after requesting one for the prior 2 days. The immediate intervention showed a bed bath was provided on 8/26/25 at 4:21 PM. c. Review of the bathing record from 6/1/25 to 8/28/25 showed the resident did not receive any bathing for 20 days between 6/21/25 and 7/11/25, 23 days between 7/22/25 and 8/15/25, and 10 days between 8/15/25 and 8/26/25. 2. Review of the quarterly MDS assessment dated [DATE] showed resident #4 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included non-traumatic brain dysfunction and non-Alzheimer's dementia. Further review showed the resident required supervision or touching assistance with bathing. The following concerns were identified: a. Review of the bathing record from 6/1/25 to 8/28/25 showed the resident did not receive any bathing for 19 days between 6/24/25 and 7/14/25, 23 days between 7/22/25 and 8/15/25, and 12 days between 8/16/25 and 8/28/25. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 535025	Facility ID: 535025 If continuation sheet Page 1 of 6

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 08/28/2025
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the annual MDS assessment dated [DATE] showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included peripheral vascular disease, obesity, right below the knee amputation, depression, toxic encephalopathy, and respiratory failure. Further review showed upper extremity impairment on 1 side, lower extremity impairment on both sides, and was dependent on staff for bathing/showering and personal hygiene. The following concern was identified: a. Review of the bathing record for August 2025 showed the resident went 11 days without bathing from 8/17/25 through 8/28/25. b. Interview with the resident on 8/28/25 at 11:45 AM revealed s/he had not received bathing in last couple of weeks, and was not happy about it. 4. Review of the admission MDS assessment dated [DATE] showed resident #3 had a BIMS score of 7 out of 15, which indicated severe cognitive impairment, and diagnoses which included fractures and other multiple trauma. Further review showed the resident had upper extremity impairment on one side and required partial/moderate assistance with personal hygiene and bathing/showering. The following concern was identified: a. Review of the bathing record for August 2025 showed the resident did not receive bathing for 9 days between 8/19/25 and 8/28/25. 5. Review of the quarterly MDS assessment dated [DATE] showed resident #6 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included non-traumatic spinal cord injury, wound infection, quadriplegia, and depression. Further review showed the resident had upper and lower extremity impairment on both sides and was dependent for personal hygiene and bathing. The following concern was identified: a. Review of the bathing record for August 2025 showed the resident did not receive bathing for 9 days between 8/7/25 and 8/16/25 and 6 days between 8/19/25 and 8/26/25. b. Interview with the resident on 8/28/25 at 12:52 PM revealed s/he was not getting showers. The resident revealed the facility provided bed baths; however, s/he did not like bed baths and wanted a shower. 6. Interview with RA #1 on 8/28/25 at 11:24 AM revealed there were no CNAs in the building. The South only had a CIT and two RA's. Further, s/he stated no baths were given that day. 7. Review of a Concern Form dated 7/18/25 showed the Resident Council reported residents would like staff to stop saying they were Short staffed a reason residents could not receive timely care such as showers, bed changes, late meds, and getting up or laying down. (continued on next page)		

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 08/28/2025
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Review of a Concern Form dated 7/7/25 showed resident #9 verbalized concerns of a staff member pushing him/her back to his/her room instead of providing a shower because the facility was to [sic] short staffed to give [him/her] a shower at that time, staff shutting off the call light without asking what the resident needed help with, and not performing shaving during showers. The actions taken showed Staff member was educated on informing residents of staffing issues as inappropriate. Residents needs must be met anytime entering the room and to not shut off the call-light until all of those needs were met in a timely manner. Showers to always be offered no matter amount of staff on floor. Nurse to assist staff member with shaves as needed. 9. Interview with the regional clinical director on 8/28/25 at 4:45 PM confirmed resident bathing was not being performed as it should be. She confirmed there were no additional bathing records for residents. 10. Review of the facility policy titled Resident Showers provided by the facility on 8/28/25 showed .1. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety .		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/21/2025
Form Approved OMB
No. 0938-0391

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 08/28/2025
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)		
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)		

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 08/28/2025
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)		
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff and resident interview, facility staffing review, grievance review, facility assessment review, and policy and procedure review, the facility failed to ensure sufficient nursing staff to provide the highest practicable physical, mental, and psychosocial well-being on 2 of 2 resident care units (North unit, South unit). The census was 69. The findings were:1. Review of the quarterly MDS assessment dated [DATE] showed resident #2 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included morbid obesity, acute respiratory failure, and disorder of skin and subcutaneous tissue. Further review showed the resident had bilateral lower extremity impairment and required partial/moderate assistance with personal hygiene and substantial/maximal assistance with bathing/showering. The following concerns were identified:a. Interview with the resident on 8/28/25 at 11:52 AM revealed the facility did not have enough staff and call lights could take between 15 and 30 minutes to be answered. The resident revealed s/he did not receive bathing regularly and prior to 8/26/25, the last shower s/he received was while s/he was in the hospital. Further interview revealed s/he had to contact the director to get the bed bath s/he received on 8/26/25.b. Review of a Concern Form dated 8/26/25 showed the resident reported s/he had not received a bed bath after requesting one for the prior 2 days. The immediate intervention showed a bed bath was provided on 8/26/25 at 4:21 PM.c. Review of the bathing record from 6/1/25 to 8/28/25 showed the resident did not receive any bathing for 20 days between 6/21/25 and 7/11/25, 23 days between 7/22/25 and 8/15/25, and 10 days between 8/15/25 and 8/26/25.2. Review of the quarterly MDS assessment dated [DATE] showed resident #4 had a BIMS score of 14 out 15, which indicated the resident was cognitively intact, and had diagnoses which included non-traumatic brain dysfunction and non-Alzheimer's dementia. Further review showed the resident required supervision or touching assistance with bathing. The following concerns were identified:a. Review of the bathing record from 6/1/25 to 8/28/25 showed the resident did not receive any bathing for 19 days between 6/24/25 and 7/14/25, 23 days between 7/22/25 and 8/15/25, and 12 days between 8/16/25 and 8/28/25.3. Review of the annual MDS assessment dated [DATE] showed resident #1 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included peripheral vascular disease, obesity, right below the knee amputation, depression, toxic encephalopathy, and respiratory failure. Further review showed upper extremity impairment on 1 side, lower extremity impairment on both sides, and was dependent on staff for bathing/showering and personal hygiene. The following concern was identified:a. Review of the bathing record for August 2025 showed the resident went 11 days without bathing from 8/17/25 through 8/28/25.b. Interview with the resident on 8/28/25 at 11:45 AM revealed s/he had not received bathing in last couple of weeks, and was not happy about it.4. Review of the admission MDS assessment dated [DATE] showed resident #3 had a BIMS score of 7 out of 15, which indicated severe cognitive impairment, and diagnoses which included fractures and other multiple trauma. Further review showed the resident had upper extremity impairment on one side and required partial/moderate assistance with personal hygiene and bathing/showering. The following concern was identified:a. Review of the bathing record for August 2025 showed the resident did not receive bathing for 9 days between 8/19/25 and 8/28/25.5. Review of the quarterly MDS assessment dated [DATE] showed resident #6 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included non-traumatic spinal cord injury, wound infection, quadriplegia, and depression. Further review showed the resident had upper and lower extremity impairment on both sides and was dependent for personal hygiene and bathing. The following concerns was identified:a. Review of the bathing record for August 2025 showed the resident did not receive bathing for 9 days between 8/7/25 and 8/16/25 and 6 days between 8/19/25 and 8/26/25.b. Interview with the resident on 8/28/25 at 12:52 PM revealed s/he was not getting showers. The resident revealed the facility provided bed baths; however, s/he did not like bed baths and wanted a shower.6. Interview with resident #10 on 8/28/25 at 3:06 PM revealed at times it took up to an hour to get call lights answered and s/he didn't always get assistance to the bathroom when needed.7. Interview with MA-C #1 on 8/28/25 at 11:46 AM revealed the facility did not have enough staff and she had to pass medications then transition to assisting residents with ADLs. Further interview revealed the North unit had close to 50 residents and staff were unable to get all the care done.8. Interview with RA #1 on 8/28/25 at 11:24 AM revealed there was no CNAs in the building and the South unit only had a CIT and two RAs. Further s/he		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/21/2025
Form Approved OMB
No. 0938-0391

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 08/28/2025
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)		
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on daily staff posting review and staff interview the facility failed to ensure the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RN, LPN, CNA were documented on the posting. The census was 69. The findings were:1. Review of the daily staff postings from 7/28/25 through 8/28/25 showed staff names, position worked, and number of hours individual staff worked; however, the posting failed to identify the total hours worked for all RNs, LPNs, and CNAs.2. Interview with the administrator on 8/28/25 at 2:47 PM confirmed the daily staff posting did not give the total number of hours for the RNs, LPNs, and the CNAs.		