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	10/24/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 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 observation, medical record review, and resident and staff interview, the facility failed to ensure residents were treated with dignity and respect during 4 random observations which affected residents #1 and #5. The census was 71. The findings were:1. Review of the 8/7/25 significant change MDS assessment for resident #1 showed s/he was determined to be severely cognitively impaired and exhibited inattention and disorganized thinking on a continuous basis, and suffered from delusions. The resident was totally dependent on staff for all areas of self-care and mobility. The following concerns were identified: a. Observation on 10/21/25 at 4:58 PM showed resident #1 was brought to the dining room and placed at the dining table with nothing in front of him/her. The resident was observed picking at the tablecloth. Meal service began at 5:07 PM and resident #1 was served his/her meal at 5:35 PM with assistance provided by CNA #2. CNA #2 was observed assisting resident #9 at 5:07 PM before moving to assist resident #1 at 5:35 PM. b. Observation on 10/22/25 at 8:36 AM showed the resident was brought to the dining room for the morning meal at 8:36 AM. At 8:53 AM the resident was offered a beverage; however, was not served his/her meal until 8:58 AM. c. Observation on 10/23/25 at 7:58 AM showed the resident was seated at a small table in the dining room, which faced the back wall, and had a glass of water in front of him/her. The resident's back was turned to the dining room so s/he was looking at the wall. At 8:38 AM the resident was observed to independently drink an entire glass of water, move the tablecloth around, and pick-up and examine a tissue box. At 8:48 AM the resident was served breakfast by a nursing student. The nursing student sat with the resident and attempted to assist him/her with the meal. The nursing student asked the resident if s/he would like something to drink; however, the nursing student did not provide a beverage. At 8:56 AM the resident began to eat with the assistance of the nursing student. At 9:15 AM the resident attempted to drink from the empty water glass; more water was provided. At this time the resident was observed to use a spoon with his/her left hand and was able to bring the food to his/her mouth. The nursing student removed the utensil from the resident's hand and began to feed the resident herself. At 9:28 AM the resident was removed from the table and was moved to the hallway in front of the North nurses' station where s/he sat until 10:53 AM when s/he was approached by a therapist and taken to the therapy room. From 9 AM until 9:28 AM the only facility staff member in the dining room was RA #2; no staff members trained to assist residents with eating were present to supervise the nursing student. d. Interview with restorative aide #1 on 10/22/25 at 1:30 PM revealed the resident required assistance with eating and was fed last so his/her food was hot. e. Interview with CNA #3 on 10/22/25 at 2:30 PM revealed only one person was assigned to the dining room during meal service and they were expected to do everything. f. Interview with CNA #2 on 10/22/25 at 4 PM revealed the dining room was only staffed with 1 person when ideally 3 people were needed. In addition, the CNA stated 2 residents required assistance with eating; one resident would be assisted while the other one had to wait. g. Interview with the DON and NHA on 10/24/25 at 12:43 PM revealed the residents, which required assistance with eating, should sit at the same table and be served at the same time. 2. Review of the 9/16/25 quarterly MDS assessment for resident #5 showed a BIMS score was not determined; however, the staff assessment for mental status showed the resident to be independent with consistent/reasonable decision making. Review of the resident's care plan, initiated on 6/25/24, showed HOARDING: [resident] has a large collection of items, posing risk for falls Interventions included to Encourage [resident] to frequently declutter, Respect [resident's] right to collect items that do not pose risk, Speak respectfully and kindly when discussing [resident's] room, and Staff to help [resident] feel safe and secure. The following concerns were identified:a. Observation and interview with resident #5 on 10/21/25 at 2:02 PM revealed s/he was upset because the [NHA] had someone come into [his/her] room and go through [his/her] things while s/he was in the hospital. The resident stated the NHA had directed the social worker to inform him/her that his/her room was a fire hazard and needed to be cleaned up. Observation of the resident's room showed the area was cluttered and unorganized and the dresser drawers appeared to be broken. b. Review of a social services note, dated 10/6/25, showed we discussed organizing [the resident's] room, [s/he] does not have family to assist in this as all family lives far away. [The resident] will need bins or bookshelves in order to complete this. [S/he] will look in to getting these so staff can help assist [him/her] to organize [his/her] room.c. Interview with the social services director on 10/22/25 at 9:59 AM revealed the NHA had sent her an email asking her to approach 7 different residents to inform them their rooms needed to be cleaned up. The social worker revealed she had

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, resident representative interview, staff interview, and policy and procedure review, the facility failed to ensure a notification of change of condition was given for 1 of 8 sample residents (#6) reviewed. The findings were:1. Review of the 10/9/25 admission MDS assessment for resident #6 showed the resident had a BIMS score of 12 out of 15 (moderately cognitively impaired), required partial to moderate assistance for toileting, showers, upper and lower body dressing, and putting on and taking off footwear. The resident had diagnoses which included diabetes mellitus type 2 (DM2), transient cerebral ischemic attack, Parkinson's disease, muscle weakness, and dysphagia. Review of the care plan showed NUTRITIONAL STATUS: [resident name] is at risk for nutrition related problems r/t [related to] Parkinson's, DM2, PNA [pneumonia], dysphagia, anemia, HTN [hypertension], chronic respiratory failure, transient cerebral ischemic attack, AOC respiratory failure, falls. Resident/family decline recommended NPO diet and request regular chopped textures. They have been educated on risks associated with declining recommendations and understand risks involved with PO intake given MBSS indicating aspiration on all textures. Date Initiated: 10/04/2025 Revision on: 10/09/2025, Target Date: 01/13/2026. Explain and reinforce to the resident the importance of maintaining the diet ordered. Review of the physician orders showed diet, regular texture, regular consistency. The following concerns were identified: a. Interview with resident #6 on 10/21/25 at 2:10 PM revealed s/he was getting enough food; however, was not sure what was being served as it was in the form of blobs. b. Interview with the residents' family on 10/23/25 at 4:25 PM revealed the resident was to be on a regular diet, not a mechanical soft diet. The resident's representative stated the facility did not notify them of the change in diet for the resident. c. Review of the meal card for the resident on 10/23/25 showed a mechanical soft chopped diet was specified for all 3 meals. d. Interview with the NHA on 10/24/25 at 12:50 PM revealed the resident's diet was recommended following a speech language pathology evaluation, and confirmed the family was not notified of the diet change. 2. Review of policy Change in a Resident's Condition or Status hand delivered on 10/23/25 at 5:15 PM by the NHA showed .4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source. b. there is a significant change in the resident's physical, mental, or psychosocial status .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, resident representative interview, and staff interview, the facility failed to ensure routine bathing was provided for 2 of 8 sample residents (#1, #5) reviewed for activities of daily living. The findings were: 1. Review of the 8/7/25 significant change assessment for resident #1 showed s/he was determined to be severely cognitively impaired and exhibited inattention and disorganized thinking on a continuous basis and suffered from delusions. The resident was totally dependent on staff for all areas of self-care and mobility. Review of the resident's ADL care plan, last revised 9/15/25, showed the resident was a 1 to 2 person assist with bathing and preferred showers on Tuesdays and Fridays. The following concerns were identified: a. Review of the October 2025 bathing documents, provided by the facility on 10/23/25 at 5:23 PM, showed the resident was given a bed bath on 10/8/25 at 11 PM and a shower on 10/16/25 (2 baths in 22 days). Interview with LPN #1 on 10/23/25 at 5:30 PM confirmed the bathing sheets were correct. b. Interview with the resident's representative on 10/23/25 at 3:57 PM revealed the facility said they were going to bathe [him/her] but do not do it. 2. Review of the 9/16/25 quarterly MDS assessment for resident #5 showed a BIMS score was not determined; however, the staff assessment for mental status showed the resident to be independent with consistent/reasonable decision making. Further review showed the resident was not coded as rejecting care during the look-back period. Review of the resident's care plan, last revised 8/20/25, showed the resident preferred a shower in the morning right after breakfast twice a week on Tuesday and Friday. Further review of the resident's care plan, initiated on 8/25/25, showed the resident was resistive to bathing/showering, at times, with interventions which included If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. Document all refusals. The following concerns were identified: a. Review of the Daily Shower Sheets, dated 10/3/25 through 10/24/25, for the resident showed the resident had received a bed bath on 10/10 after refusing on 10/8 and 10/9, and was in the hospital from 10/17 to 10/19. Review of the nurse progress notes showed the resident was educated on the importance of bathing on 10/9/25 and 10/15/25. There was no documentation the resident had refused to be bathed. No further documentation was available.3. Interview with the DON and NHA on 10/24/25 at 12:40 PM revealed they had identified the need to provide a better quality of care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 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 observation, medical record review, staff interview, and policy review the facility failed to ensure interventions to prevent ulcers development were implemented for 2 of 4 residents (#1, #2) reviewed for pressure ulcers. The findings were:1 Review of the 2/17/25 admission MDS assessment, showed resident #1 was coded as being severely cognitively impaired and had diagnoses which included non-traumatic brain dysfunction, dementia, severe, with mood disturbance, deep vein thrombosis, diabetes mellitus, thyroid disorder, arthritis, non-Alzheimer's dementia, malnutrition, post traumatic stress disorder, anxiety, depression, disorder of bone density and structure, and other intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain. The assessment showed the resident required assistance of supervision or setup for toileting, showers, upper body dressing, lower body dressing, putting on footwear, and personal hygiene. Further, review showed the resident was at risk for pressure ulcer development, did not have any pressure ulcers, and had a pressure reducing device in bed and chair. Review of the 5/7/25 quarterly MDS assessment showed the resident was coded as being severely cognitively impaired. The assessment showed the resident was independent with eating, oral hygiene, and required supervision/setup assistance for toileting, showers, upper body dressing, lower body dressing, putting on footwear, and personal hygiene. Further review the resident was at risk for pressure ulcer development, did not have any pressure ulcers, and had a pressure reducing chair. Review of the Skin and Wound - Total Body Skin Assessments for 6/15/25 through 10/17/25 showed new wounds 0, except on 7/30/25 which showed 1 new wound. Review of the medical records showed the left heel wound was new on 7/29/25, the left dorsum wound was new on 7/29/25, and the right medial heel wound was new on 9/1/25. The following concerns were identified: a. Review of the 8/7/25 significant change MDS assessment showed the resident was coded as being severely cognitive impaired. The assessment showed the resident was totally dependent for the ADLs of eating, oral hygiene, toilet, shower, upper body dress, lower body dress, putting on footwear, and personal hygiene. Further, review showed the resident was at risk for pressure ulcer development and had one unhealed stage 3 pressure ulcer. The resident had a pressure reducing chair and bed and was receiving pressure ulcer/injury care. b. Review of the care plan showed SKIN/CONNECTIVE TISSUE: [Residents name] is at risk for skin impairment related to. [Resident name] will maintain clean and intact skin throughout review, initiated on 2/12/25 with the target date of: 12/30/25. The intervention was weekly skin checks by licensed nurse dated 2/12/25. Further review showed other interventions were added on 10/21/25 e.g. barrier cream as needed, cushion around and under boney prominences, good nutrition and hydration, pressure reducing cushion to wheelchair, needs pressure relieving device to bed. c. Review of the Skin and Wound - Total Body Skin assessment dated [DATE] showed the residents' skin turgor was poor elasticity, skin color pale, temperature was warm (normal, moisture was normal, condition was dry, new wounds was 1. Review of the nursing progress notes showed on 7/30/25 at 1:36 PM Ensure resident to wear Gripper socks in bed and at all times., and Pt [patient] is in puff boots. d. Review of Compassionate Concierge Physicians (CCP) Mobile Wound Care note dated 7/31/25 showed .New patient Eval for Stage 3 Pressure Ulcer of Left Heel .Polaris staff reporting pressure wound to left heel that started about two weeks prior. Upon examination, there are offloading booties present. Left heel wound present with bruising . Review of the 10/20/25 wound care team notes showed .wound location: left heel, left medial foot, right heel .right hip the facility to manage. Frequency was CCP to change All dressing 2 times a week (Mon/Thurs). Polaris left heel: change 5 times a week and as needed if soiled or misplaced (Sun/Tues/Wed/Fri/Sat and as needed), All other wounds change 1 time a week and as needed if soiled or misplaced (Sat and as needed). e. Observation of the resident on 10/23/25 at 12:40 PM, while CCP was finishing wound care, showed the resident was lying on his/her back, heels down on the mattress, blue boots were on the bed, a heel lift cushion was beside the bed, a ribbed mattress, and a wedge was between the resident's legs. Interview at that time with the CCP provider revealed the resident had a new pressure ulcer to the buttock stage 1. The CCP provider stated they were going to recommend an air mattress. Further, interview revealed the facility calls the agency when they want a wound check. f. Interview with the wound care nurse on 10/22/25 at 1 PM revealed she was hired on as the wound care nurse in August. She stated she was doing the best she could with the assessments; however, she continued to be assigned to the floor to work. g. Interview with a CNA on 10/22/25 during the afternoon revealed when s/he did the bed bath for the resident the day before the pressure ulcer was

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on medical record review, resident and staff interview, and review of concern forms, the facility failed to provide timely incontinence care to 2 of 8 sample residents (#1, #5). The findings were:1. Review of the 8/7/25 significant change assessment for resident #1 showed s/he was determined to be severely cognitively impaired and exhibited inattention and disorganized thinking on a continuous basis, and suffered from delusions. The resident was totally dependent on staff for all areas of self-care and mobility. The following concerns were identified: a. Observation on 10/23/25 at 7:58 AM showed the resident was seated at a small table in the dining room, which faced the back wall, and had a glass of water in front of him/her. At 9:28 AM the resident was removed from the table and was moved to the hallway in front of the North nurses' station where s/he sat until 10:53 AM when s/he was approached by a therapist and taken to the therapy room. The resident remained in the therapy room and was a passive participant until 11:50 AM when s/he was taken back to the dining room and placed at the same table as before. The resident was offered a glass of water at 11:53 AM in which s/he drank half. At 12:11 PM the contractual wound care nurse approached the resident at the dining room table and then transferred him/her back his/her room to provide wound care. The resident was transferred using a Hoyer lift by LPN #1 and CNA #2 to his/her bed and then exited the room for the wound care team to provide care. At 12:59 PM the wound care team exited the resident's room. At 1:50 PM RA #1 was observed bringing the resident's noon meal into the room and then left stating she needed to find a nurse or CNA to assist the resident with the meal. At 1:53 PM LPN #1 and a nursing student entered the room where incontinence care was provided (approximately 6 hours). LPN #1 confirmed the resident's brief was wet. 2. Review of the 9/16/25 quarterly MDS assessment for resident #5 showed a BIMS score was not determined; however, the staff assessment for mental status showed the resident to be independent with consistent/reasonable decision making. Further review showed the resident had an indwelling catheter and was frequently incontinent of bowel. Review of the resident's ADL care plan, last revised 9/5/25, showed the resident required a bedpan for bowel movements with the extensive assist of 2 staff members for placement. The following concerns were identified.a. Interview with the resident on 10/21/25 at 2:02 PM revealed s/he was not receiving care in a timely manner and had telephoned the facility to request help because his/her call light was not being answered. Review of a 10/20/25 concern form, provided by the resident showed the form was completed with the assistance of the business office manager (BOM). The description of the concern showed Resident had to call the facility to get assistance on the bed pan. [BOM] in the business office came to address needs. [Resident] stated [s/he] has been waiting to be put on bed pan. [S/he] stated [CNA #5] came to his/her room stated she did not have time to put resident on bedpan due to needing to complete bed baths. Call light was going off the whole-time cares were being performed and nobody covered the light. This was on for about an hour and unsure how long it was on prior. This is the second time resident had to call the facility to have [his/her] needs addressed. The first time was 10/16/25. It was also evident that pericare was not being performed. The same staff member was working from (sic) 10/20/25 and 10/16/25 (sic) was working the floor on these occasions. In addition, the concern form stated this concern had been previously voiced. b. Interview with the BOM on 10/22/25 at 1 PM confirmed the resident had phoned the facility asking for assistance. The BOM stated she was also a CNA and went to the resident's room to assist the resident with the bedpan. The BOM confirmed the resident's call light was on for approximately 1 hour while she provided care to the resident with no response from the unit staff. 2. Interview with the DON and NHA on 10/24/25 at 12:40 PM revealed they had identified the need to provide a better quality of care.

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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)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, medical record review, resident representative and resident interview, review of resident council minutes, and concern forms, and staff interview, the facility failed to ensure sufficient nursing staff was available to provide the highest practicable physical, mental, and psychosocial well-being on 2 of 2 resident care units (North hall, South hall). The census was 71. The findings were: 1. Review of the 8/7/25 significant change MDS assessment for resident #1 showed s/he was determined to be severely cognitively impaired and exhibited inattention and disorganized thinking on a continuous basis, and suffered from delusions. The resident was totally dependent on staff for all areas of self-care and mobility. Review of the resident's ADL care plan, last revised 9/15/25, showed the resident was a 1 to 2 person assist with bathing and preferred showers on Tuesdays and Fridays. The following concerns were identified: a. Observation on 10/21/25 at 4:58 PM showed resident #1 was brought to the dining room and placed at the dining table with nothing in front of him/her. The resident was observed picking at the tablecloth. Meal service began at 5:07 PM and resident #1 was served his/her meal at 5:35 PM with the assistance of CNA #2. CNA #2 was observed assisting resident #9 at 5:07 PM before moving to assist resident #1. b. Observation on 10/22/25 at 8:36 AM showed the resident was brought to the dining room for the morning meal at 8:36 AM. At 8:53 AM the resident was offered a beverage; however, was not served his/her meal until 8:58 AM. c. Observation on 10/23/25 at 7:58 AM showed the resident was seated at a small table in the dining room, which faced the back wall, and had a glass of water in front of him/her. The resident's back was turned to the dining room so s/he was looking at the wall. At 8:38 AM the resident was observed to independently drink an entire glass of water, move the tablecloth around, and pick-up and examine a tissue box. At 8:48 AM the resident was served breakfast by a nursing student. The nursing student sat with the resident and attempted to assist him/her with the meal. The nursing student asked the resident if s/he would like something to drink; however, the nursing student did not provide a beverage. At 8:56 AM the resident began to eat with the assistance of the nursing student. At 9:15 AM the resident attempted to drink from the empty water glass; more water was provided. At this time the resident was observed to use a spoon with his/her left hand and was able to bring the food to his/her mouth. The nursing student removed the utensil from the resident's hand and began to feed the resident herself. At 9:28 AM the resident was removed from the table and was moved to the hallway in front of the North nurses' station where s/he sat until 10:53 AM when s/he was approached by a therapist and taken to the therapy room. From 9 AM until 9:28 AM the only facility staff member in the dining room was RA #2; no staff members trained to assist residents with eating were present to supervise the nursing student. d. Interview with restorative aide #1 on 10/22/25 at 1:30 PM revealed the resident required assistance with eating was served last so his/her food was hot. e. Interview with CNA #3 on 10/22/25 at 2:30 PM revealed only one person was assigned to the dining room during meal service and they were expected to do everything. f. Interview with CNA #2 on 10/22/25 at 4 PM revealed the dining room was only staffed with 1 person when ideally 3 people were needed. In addition, the CNA stated 2 residents required assistance with eating; one resident would be assisted while the other one had to wait. g. Review of the bathing documents provided by the facility on 10/23/25 at 5:23 PM showed the resident was given a bed bath on 10/8/25 at 11 PM and a shower on 10/16/25 (2 baths in 22 days.) Interview with LPN #1 on 10/23/25 at 5:30 PM confirmed the bathing sheets were correct. h. Interview with the resident's representative on 10/23/25 at 3:57 PM revealed the facility said they were going to bathe [him/her] but do not do it. i. Observation on 10/23/25 at 7:58 AM showed the resident was seated at a small table in the dining room, which faced the back wall, and had a glass of water in front of him/her. At 9:28 AM the resident was removed from the table and was moved to the hallway in front of the North nurses' station where s/he sat until 10:53 AM when s/he was approached by a therapist and taken to the therapy room. The resident remained in the therapy room and was a passive participant until 11:50 AM when s/he was taken back to the dining room and placed at the same table as before. The resident was offered a glass of water at 11:53 AM in which s/he drank half. At 12:11 PM the contractual wound care nurse approached the resident at the dining room table and then transferred him/her back his/her room to provide wound care. The resident was transferred using a Hoyer lift by LPN #1 and CNA #2 to his/her bed and then exited the room for the wound care team to provide care. At 12:59 PM the wound care team exited the resident's room. At 1:50 PM RA #1 was observed bringing the resident's noon meal into the room and then left stating she needed to find a nurse or CNA to assist the resident with the meal. At 1:53 PM LPN #1 and a nursing student entered the room where incontinence care

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	10/24/2025

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 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Actual harm Residents Affected - Few	Based on medical record review, staff interview, and review of medication interactions, the facility failed to ensure residents did not receive unnecessary medications for 1 of 8 (#1) sample residents reviewed. This failure caused harm to resident #8 whose functional capacity declined from independent to dependent. The findings were: 1. Review of the 2/7/25 admission MDS assessment for resident #1 showed the resident was coded as being severely cognitively impaired with inattention and disorganized thinking continuously present; wandered 4 to 6 days of the look-back period; was coded as requiring supervision or setup assistance for all self-care areas and was independent with mobility. The resident was not coded as receiving an anticonvulsant medication. Review of the 5/7/25 quarterly MDS assessment showed the resident continued to be independent with mobility and was not coded as receiving an anticonvulsant medication. Review of the 8/7/25 significant change MDS assessment showed the resident was coded as being totally dependent on staff for all self-care and mobility areas. The resident was coded as receiving an anticonvulsant. The following concerns were identified: a. Interview with the resident's representative on 10/23/25 at 3:50 PM revealed he recalled the resident participated in the July 4th celebration at the facility and by July 19th was unable to function. The resident's representative stated the facility had failed to follow orders from a neurologist to discontinue the valproic acid (anticonvulsant) medication which he thought caused the resident to be overmedicated. b. Review of the 7/10/25 and 7/26/25 hospital's After Visit Summary showed the reason for the resident's visit was Altered Mental Status. Further review of the 7/26/25 After Visit Summary showed the resident had diagnoses of somnolence and a history of seizure. The discharge instructions showed Please start taking the lacosamide (anticonvulsant), in 2 days, stop the valproic acid. If breakthrough seizures, please increase the lacosamide to 100 mg twice daily. If worsening symptoms return to the Ed. Further instructions stated a follow-up appointment with a neurologist should be scheduled as soon as possible. c. Review of the July 2025 medication administration record (MAR) showed the resident was administered 5 mg of olanzapine twice daily for behaviors with a start date of 6/30/25 and a discontinue date of 7/25/25; 5 mg of olanzapine once daily for behaviors with a start date of 7/25/25; 100 mg of lacosamide two times a day for seizures with a start date of 6/15/25 and a discontinue date of 7/26/25; 50 mg of lacosamide two times a day for post traumatic seizures with a start date of 7/26/25; and 5 ml of 250 mg/5ml valproic acid oral solution 3 times a day for post traumatic seizures with an order date of 7/1/25 and a discontinue date of 8/28/25. The resident was also prescribed 1 ml of lorazepam-diphenhydramine-haloperidol-ondansetron cream to be applied topically every 4 hours as needed with a start date of 5/19/25. The resident received 1 dose on 7/1 and 7/2; 2 doses on 7/3 and 7/5; 3 doses on 7/6, 1 dose on 7/8, 3 doses on 7/9, 1 dose on 7/10, 7/12, 7/13, and 7/14. No further doses were applied and the medication was discontinued on 8/28/25.d. Review of the August 2025 MAR showed 5 ml of a 250 mg/5 ml valproic acid oral solution was to be administered 3 times per day for post traumatic seizures with a start date of 7/1/25 and a discontinue date of 8/18/25. Further review showed an order dated 8/18/25 for the same dose of valproic acid to be administered two times per day every Tuesday, Wednesday, and Thursday and then decreased to 2.5 ml once a day for 3 days and then to discontinue. The medication was discontinued on 8/29/25. e. Continued review of the resident's August 2025 MAR showed the resident was administered melatonin for insomnia starting on 5/29/25, paroxetine (antidepressant) for major depressive disorder starting on 6/6/25, and olanzapine (an atypical antipsychotic) for unspecified dementia, severe with mood disturbance, and major depressive disorder starting on 7/25/25.f. Review of a 6/25/25 nurse's note showed the resident had behaviors of wandering, intrusive pacing, clenching fists, sharp voacal (sic) tone, shrugging away staff who approach to greet [him/her] and turning [his/her] back and changing directions, 'stating, Leave me alone!g. Review of the nurses' progress notes for July 2025 failed to include when or what triggered the decline in the resident's functional status.h. Review of a 8/4/25 nurse's note showed Follow up scheduled today from previous hospital visit at neurology .Resident is unable at times to sit up in wheelchair for staff to attempt to take [him/her] .i. Review of a 8/17/25 nurse's note, showed Residents son approached this nurse and stated that he wants resident off of Valproic Acid. This nurse educated son of mechanism of action of the medication and reason for being on this medication and the risk of seizure activity when taken off the drug. Residents son stated an understanding and is willing to take the risk of resident being tapered off medication. Residents son requested keppa (sic) as a alternate. This nurse notified NP and awaiting orders. j. Interview with CNA #4 on 10/22/25 at 4:30 PM revealed the resident was ambulatory and had