

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 06/26/2024
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>37220</p> <p>Based on medical record review and staff interview, the facility failed to develop a baseline care plan which addressed the immediate needs of the residents for 1 of 5 (#117) newly admitted residents reviewed. The findings were:</p> <ol style="list-style-type: none"> Review of the medical record for resident #117 showed the resident was admitted from the hospital on 6/6/24 and had diagnoses which included hypertensive chronic kidney disease with stage 5 chronic kidney disease and dependence on renal dialysis. Review of the resident's 6/7/24 baseline care plan showed the focus area of dialysis was left blank. Interview on 6/26/24 at 10:40 AM with the DON confirmed the resident's baseline care plan was incomplete.

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>37220</p> <p>Based on medical record review, staff and resident interview, and policy and procedure review, the facility failed to ensure the comprehensive care plan was revised as needed to reflect the resident's current needs for 1 of 5 sample residents (#58) reviewed for smoking. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the 3/10/24 MDS assessment showed resident #58 had a BIMS score of 5 out of 15 which indicated severe cognitive impairment. Interview with the resident on 6/25/24 at 8:19 AM revealed s/he smoked on a regular basis. Review of the 6/17/24 safe smoking assessment showed the resident was required to wear a smoking apron. The following concerns were identified: <ul style="list-style-type: none"> a. Review of the resident's care plan showed the care plan had not been revised to include goals and interventions related to the use of tobacco. 2. Interview with the DON on 6/25/24 at 2:15 PM confirmed the care plan had not been updated to reflect the resident's use of tobacco. 3. Review of the 5/2/24 Resident Smoking Policy showed .8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan .10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan.

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220</p> <p>Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure the environment was free of accident hazards for 1 of 5 sample residents (#117) reviewed for smoking. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the 6/9/24 admission MDS assessment showed resident #117 had a BIMS score of 15, which indicated the resident was cognitively intact, and was coded as not using tobacco. The findings were: <ol style="list-style-type: none"> a. Observation on 6/23/24 at 11:36 AM showed the resident was smoking in the designated outdoor smoking area under staff supervision. b. Interview with the resident on 6/25/24 at 7:56 AM revealed the s/he did not start smoking until 2 weeks after s/he was admitted . The resident stated s/he wore a smoking apron while smoking but otherwise did not have any restrictions. c. Review of the smoking assessment dated [DATE] showed the resident was a non-smoker. There was no evidence a safe smoking assessment had been completed after the resident had chosen to begin smoking. 2. Interview with the DON on 6/25/24 at 2:22 PM revealed a safe smoking assessment had not been completed. 3. Review of the policy and procedure provided by the DON on 6/25/24 at 1:50 PM showed .5. All resident's will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. 6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan . 		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220</p> <p>Based on medical record review and staff interview, the facility failed to have a system in place to ensure communication with the dialysis center was documented in the medical record for 3 of 4 residents (#11, #35, #117) who received dialysis services. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the medical record showed resident #11 was admitted to the facility on [DATE], discharged with return anticipated on 5/20/24, and readmitted to the facility on [DATE]. Review of the resident's care plan showed the resident was to receive dialysis from an offsite dialysis center every Monday, Wednesday, and Friday. Review of the 2024 May and June Dialysis Communication Record forms between the dialysis center and the facility showed no documentation for the 5/17, 5/31, 6/12, 6/17, 6/19, 6/21, and 6/24 treatments. 2. Review of the 3/31/24 quarterly MDS assessment showed resident #35 was admitted to the facility on [DATE] and received dialysis services. Review of the physician orders showed the resident was to receive dialysis from an offsite dialysis center every Tuesday, Thursday, and Saturday. Review of the 2024 March, April, May, and June Dialysis Communication Record forms between the dialysis center and the facility showed no documentation for the 3/5, 3/7, 3/9, 3/21, 6/4, 6/6, and 6/8 treatments. 2. Review of the medical record for resident #117 showed s/he was admitted to the facility on [DATE]. Review of the physician orders showed the resident was to receive dialysis from an offsite dialysis center every Monday, Wednesday, and Friday. Review of the June 2024 Dialysis Communication Record forms between the dialysis center and the facility showed no documentation for the 6/12 treatment. 3. Interview on 6/25/24 at 3:26 PM with RN #1 revealed the facility used to have dialysis binders to keep track of the communication forms; however, the facility had discontinued the binders. <p>37603</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>37603</p> <p>Based on observation, and staff interview, the facility failed to ensure the daily staff posting was updated daily for 1 of 2 random observations (6/23/24). The census was 64. The findings were:</p> <ol style="list-style-type: none"> 1. Observation on 6/23/24 at 1:34 PM showed the facility's daily staff posting was on the front wall by the main entrance and was dated 6/20/24. 2. Observation on 6/23/24 at 5:30 PM showed the staff posting had been changed to Sunday 6/23/24. Interview with the nursing home administrator at that time confirmed the posting had been recently changed to reflect the current day's information. 3. Interview with the scheduler on 6/24/24 at 10:39 AM revealed she was normally responsible for the daily staff posting; however, she did not work weekends. In addition, the scheduler confirmed she did not change the daily staff posting on Friday 6/21/24, because she was working on the floor. The scheduler was not aware of whose responsibility it was on the weekends to update the posting. 4. Interview with the DON on 6/24/24 at 10:39 AM revealed it was the responsibility of the manager on duty to update the daily staff posting on the weekend.

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220</p> <p>Based on medical record review, staff interview, and review of facility policies, and review of the CDC immunization recommendations, the facility failed to ensure residents received the pneumococcal immunization based on CDC recommendations for 1 of 5 sample residents (#43) reviewed for immunizations. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the medical record showed resident #43 was [AGE] years old. Further review showed the resident received the Prevnar 23 vaccine on 1/18/17 and had signed a consent form on 9/11/23 to receive the PCV20 vaccine. There was no evidence the resident had received the vaccination. 2. Interview with the infection preventionist on 6/26/24 at 11:09 AM revealed the resident had not been administered the PCV 15 or PCV20 vaccine due to an oversight. 3. Review of the 9/8/23 Pneumococcal Vaccine policy showed .The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations. 4. According to the Adult Immunization Schedule by the CDC located at https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-schedule-notes.html#note-pneumo (accessed on 6/27/24) showed individuals 65 or older who previously received only the PPSV23 vaccine should be administered either the PCV15 or PCV20 at least 1 year after the PPSV23 dose.