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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Rehabilitation and Care Center	2700 E 12th Street Cheyenne, WY 82001

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medications for 1 of 5 sample residents (#68) reviewed. The findings were:1. Review of a 9/9/25 provider progress note for resident #68 showed the resident had Alzheimer's disease, unspecified; dementia in other diseases classified elsewhere without behavioral disturbance; and restlessness and agitation. Further review showed The patient will continue to receive supportive interventions aimed at minimizing agitation and promoting cooperation, including structured activities, calm environments, and therapeutic communication strategies. Nursing staff will closely monitor for recurrent behavioral escalation, medication side effects, or acute changes in condition. To rule out underlying medical contributors to agitation, the following laboratory studies are ordered: Urinalysis with culture and sensitivity (UA w/ C&S), Complete Metabolic Panel (CMP), and Complete Blood Count (CBC). Results will be reviewed to guide further management. The care plan for [resident name] focuses on management of acute agitation and behavioral escalation in the context of underlying cognitive and functional needs. She will continue to be supported in calm, structured environments with use of de-escalation techniques including reduced lighting, therapeutic music, and one-on-one supportive interaction as needed. Nursing staff will monitor for recurrent agitation, provide reassurance, and implement redirection strategies early to prevent escalation. The interdisciplinary team, including nursing, rehabilitation, and providers, will maintain communication regarding episodes and reinforce individualized behavioral interventions to promote safety, cooperation, and overall well-being. Review of the 12/30/25 quarterly MDS assessment showed the resident was administered an antipsychotic medication during the 7-day look-back period. The resident had diagnoses of non-traumatic brain dysfunction, cancer, hypertension, Alzheimer's disease, non-Alzheimer's dementia, unspecified pulmonary disease, respiratory failure, pain in right hip, primary thrombophilia, hearing loss, osteoarthritis, abnormalities of gait and mobility, and lack of coordination. The following concerns were identified:a. Review of the resident's care plan, initiated on 10/29/25, showed the resident used psychotropic medications related to dementia with behavioral disturbance. Review of the September 2025 medication administration record showed the resident was administered 25 milligrams of Seroquel (antipsychotic medication) two times a day for dementia with behavioral disturbances with a start date of 9/9/25. Review of the entire medical record showed no evidence the diagnosis of dementia with behavioral disturbances had been documented by a provider. b. Interview with the DON on 1/15/26 at 10:57 AM confirmed the diagnosis of dementia with behavioral disturbances was not documented in the resident's medical record.

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on medical record review, staff interview, and review of the MDS 3.0 RAI (Resident Assessment Instrument) manual, the facility failed to ensure a significant change assessment (SCSA) was completed for 1 of 25 sample residents (#32) reviewed. The findings were: 1. Review of the 8/11/25 annual MDS assessment for resident #32 showed s/he received hospice care. Review of the 11/11/25 quarterly MDS assessment showed the resident was not receiving hospice care. Review of the resident's medical record showed no documentation of when the resident had been discharged from hospice. Interview with the business office manager on 1/14/26 at 2:27 PM revealed she had changed to resident's payer source on 10/24/25. Interview with the MDS coordinator on 1/14/25 at 2:18 PM confirmed a significant change MDS assessment had not been completed on the resident following his/her discharge from hospice care. 2. Review of the October 2023 CMS RAI manual version 3.0 version 1.18.11 showed An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD [assessment reference date] must be within 14 days from one of the following: 1) the effective date of the hospice CMS's RAI Version 3.0 Manual CH 2: Assessments for the RAI October 2023 Page 2-26 election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to ensure a resident receiving enteral feeding received appropriate care and services to prevent complications for 1 of 1 sample resident (#62) reviewed for tube feeding. The findings were: 1. Review of the 11/6/25 comprehensive MDS assessment showed resident #62 had a memory problem with moderately impaired cognitive skills for daily decision making, and had diagnoses which included respiratory failure, hemiplegia, or hemiparesis, traumatic brain injury, and cerebral edema and edema of the larynx. Further review showed the resident had a feeding tube. Review of the physician orders dated 11/21/25 showed the resident received enteral feeding through the feeding tube once daily. The following concerns were identified:a. Observation on 1/13/26 at 6 PM showed RN # 1 administer the resident his/her enteral tube feeding; however, the RN did not check placement, residual volume, nor was the resident's head of bed elevated.b. Review of the physician orders dated 10/31/25, showed residual and verification of the tube placement must be checked prior to administering enteral feeding. c. Review of the care plan, last revised on 11/7/25, showed, Check for placement and gastric contents/residual volume per facility protocol, hold feed if contents/residual is over 500 cc (cubic centimeters). Further review showed the resident's head of the bed should have been elevated 30 to 45 degrees during feeding and for 1 hour following to prevent aspiration pneumonia. d. Review of the facility policy titled Care and Treatment of Feeding Tubes provided by the DON on 11/14/26, showed .6. In accordance with facility protocol licensed nurses will monitor and check the feeding tube is in the right location.e. Interview with the DON on 1/14/26 at 9:44 AM confirmed staff were expected to check placement, residual of the stomach contents, and elevate the head of the bed prior to starting the feeding solution.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. This requirement has not been met as evidenced by: Based on employee record review, and staff interview, the facility failed to obtain CNA abuse prior to resident contact for registry verification in 1 of 3 (CNA #2) employee files reviewed. 1. Review of CNA #2's personnel record showed no evidence the facility had obtained CNA abuse registry verification prior to resident contact.2. Interview with the human resource manager on 1/13/26 at 4:32 PM confirmed that he was not aware the CNA abuse registry was to be verified.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on facility documentation, staff interview, and policy and procedure review, the facility failed to ensure a system was in place to maintain documentation of the pharmacist's monthly medication review for 5 of 5 sample residents (#1, #2, #5, #54, #68) reviewed for unnecessary medications. In addition the facility failed to act on a pharmacy recommendation for 1 of 5 sample residents (#5) for unnecessary medications. The findings were: 1. Review of the facility's documentation showed a monthly medication review was performed on resident #1 in June, November, and December of 2025. The facility was unable to located any further documentation. 2. Review of the facility's documentation showed a monthly medication review was performed on resident #2 in November 2025. The facility was unable to locate any further documentation. 3. Review of the facility documentation showed no evidence a monthly medication review had been completed for resident #5 in December 2025. Further review showed a monthly medication review was performed in November 2025 with the pharmacy recommendation of a trial dose reduction of Olanzapine from 5mg to 2. 5mg at bedtime. Review of the resident's orders showed the medication was never decreased. Further review of physician orders dated 12/6/25 showed an increase in olanzapine dose from 5mg to 7.5mg. Interview with the facility nurse practitioner on 1/15/26 at 10:13 AM confirmed Olanzapine dose was increased and not decreased. 4. Review of the facility's documentation showed a monthly medication review was performed on resident #54 in November and December of 2025. The facility was unable to locate any further documentation.5. Review of the facility's documentation showed a monthly medication review was performed on resident #68 in November and December of 2025. The facility was unable to locate any further documentation.6. Interview with the DON on 1/14/26 at 4:36 PM revealed the facility had changed pharmacies in November of 2025 and she was unable to locate the documentation from the previous pharmacy.7. Review of the Pharmacy Services Policy and Procedure, provided by the NHA on 1/15/26 at 2 PM showed .III. Drug Regimen Review A. The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. This requirement was not met as evidenced by:Based on observation, staff interview, review of manufacturer's instructions, and policy and procedure review, the facility failed to label and provide the date medications were opened in 1 of 4 medication carts (Yellowstone hall). The findings were: 1. Observation of the Yellowstone medication cart on 1/13/26 at 3:39 PM showed a multidose vial of Lantus insulin which was opened and not labeled. 2. Interview with RN # 2 on 1/13/26 at 3:40 PM revealed that insulin vials should have been labeled with the date they were opened and confirmed the vial was opened and not dated.3. Interview with the DON on 1/13/26 at 5:22 PM confirmed that staff were expected to label insulin vials with the opening date. 4. Review of the manufacturer's instructions titled Patient Medication Information - Lantus vial last revised 12/1/21 showed opened insulin vials must be discarded after 28 days of opening. 5. Review of the policy titled Multi-dose Vials last revised 2016, showed .2. Multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured (unless otherwise specified by the manufacturer).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of the 2022 FDA Food Code, the facility failed to ensure a sanitary environment in 1 of 1 kitchen. The census was 72. The findings were:1. Observation on 1/14/26 at 9:31 AM showed cook #1 was performing various tasks in the kitchen; doffed his gloves, and without performing hand hygiene donned new gloves; placed two pots of water on the stove to boil; and retrieved fresh tomatoes from the walk-in refrigerator. After washing the tomatoes cook #1 used his same gloved hands and began slicing the tomatoes; discarded some tomato waste into a nearby garbage can, touched the sides of the can with his gloved hands in the process, and then resumed dicing the tomatoes. [NAME] #1 placed the diced tomatoes into a stainless-steel container; moved a cart of dirty dishes into the kitchen; removed his gloves, and without performing hand hygiene donned new gloves and continued to dice the tomatoes. 2. Observation on 1/14/26 at 10:11 AM showed cook #1 doffed his gloves, washed his hands, donned new gloves, and then adjusted his face mask with his gloved hands. [NAME] #1 opened cooler #1 and retrieved a plastic container of shredded cheese and proceeded to make individual salads. [NAME] #1 used his gloved hands to transfer salad greens from a container into individual salad bowls; added diced celery and tomatoes in the same manner; and then reached into the cheese container to add cheese to the bowls. After completing the first tray of 9 salad bowls cook #1 retrieved a date marking gun to date the individual salad bowls, and placed the salads into cooler #3. [NAME] #1 continued in the same manner and prepared a second tray of 12 bowls of salad. [NAME] #2 doffed his gloves at 10:21 AM and without performing hand hygiene donned new gloves and prepared a third tray of 12 salad bowls in the same manner as before. 3. Interview with the dietary manager on 1/15/26 at 1:19 PM confirmed hand hygiene was not performed as required. 4. According to the 2022 FDA Food Code showed 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interview, the facility failed to ensure effective infection control techniques were utilized during 1 of 2 dining observations. The census was 72. The findings were:1. Observation on 1/12/26 at 5:44 PM showed CNA #1 was assisting residents with eating in the assisted dining room. The CNA was observed picking up a sandwich for resident #5 with her bare hands and handed the sandwich to the resident. Interview with the CNA at 5:55 PM revealed she knew she had made a mistake; however, was trying to assist the resident because she did not want the resident to sit alone without assistance. 2. Interview with the infection preventionist on 1/15/26 at 1 PM revealed it was her expectation for staff to sanitize their hands and then use gloves if they had to touch a resident's food.