STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys 11/13/25 through 11/14/25. The survey was prompted by complaint intakes 2652282 and 2651381 The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, staff, resident, and resident representative interview, facility incident review, and policy and procedure	F0600	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0600 SS = G	Continued from page 1 review, the facility failed to protect residents' right to be free from physical abuse by another resident for 1 of 6 sample residents (#1) reviewed for abuse. This failure resulted actual harm to resident #1 and resident #2. Corrective measures were implemented prior to the survey and compliance was determined to be met on 10/23/25. The findings were: 1. Review of the quarterly MDS assessment dated 9/12/25 showed resident #1 had a brief interview for mental status (BIMS) score of 15 out 15, which indicated the resident was cognitively intact, and diagnoses which included heart failure, renal insufficiency, diabetes mellitus, and cerebrovascular accident. Further review showed the resident had no behaviors exhibited, used a wheelchair for mobility, and was dependent on staff for transfers. Review of the quarterly MDS assessment dated 7/31/25 showed resident #2 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and diagnoses which included non-Alzheimer's dementia and renal insufficiency. Further review showed the resident had no behaviors exhibited, used a walker for mobility, and required supervision or touching assistance with transfers. The following concerns were identified: a. Observation on 11/13/25 at 11:28 AM showed resident #2 was in his/her room, in bed, and s/he had a cast present to his/her right hand. Interview with the resident at that time revealed s/he was unsure how the injury to his/her hand occurred; however, s/he felt s/he could benefit from counseling services. b. Review of a progress note for resident #1 dated 10/17/25 and timed 10 AM showed "LATE ENTRY Note Text : On 10/17/2025 this nurse was alerted to an incident with resident and room mate. This nurse was not the first on scene. Both residents were separated immediately. Floor nurse stated he left a message with contact number on file. Resident sent to hospital for further evaluation. Resident was moved to a different room." c. Review of a facility incident report dated 10/17/25 and timed 9:45 AM showed "There was a noise commotion. A staff member responded. Found one resident on the floor. Both residents holding the walker. Staff intervened and separated both residents to ensure safety. Nurse evaluated both residents and provider notified. [Resident #1] was sent to the hospital to be further evaluated." Further, the report showed "[Resident #1] had a swollen jaw on the right side and was transferred to the hospital for further evaluation. [Resident #2] was bleeding on the right side of his	F0600		

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F0600 SS = G	Continued from page 2 head and transferred to the hospital for further evaluation." d. Review of a progress note for resident #1 dated 10/18/25 and timed 8:30 AM showed "Note Text : Returned [Name], [Resident #1]'s friends [sic] call from yesterday to follow up regarding the incident, to see if [s/he] had any additional questions or concerns. [S/he] said they did some blood work on [resident #1] and found some sort of blood infection, affecting [his/her] spinal chord [sic],so they are sending [him/her] to a Colorado hospital. [S/he] will follow up with [resident #1] today and get more details. [S/He] said if [s/he] has any further questions or concerns, [s/he] will contact me." e. Review of a progress note for resident #1 dated 10/20/25 and timed 3:45 PM showed "Note Text : [Name] from [hospital name] called Polaris regarding [resident #1]'s return to Polaris. [S/He] states [s/he] does not wish to return to Polaris with the other resident still remaining at Polaris. [Name] asked for dialysis days and stated that she would be sending referrals to other facilities in Cheyenne." f. Review of a progress note for resident #2 dated 10/20/25 and timed 2:04 PM showed "Note Text : On 10/17/2025 this nurse was alerted to an incident with resident and room mate. This nurse was not the first on scene. Both residents were separated immediately. Floor nurse stated he tried to contact the number on file, but the number was not working. Resident sent to hospital for further evaluation." g. Review of an emergency medicine note for resident #1 dated 10/17/25 showed the chief complaint was "Assault Victim." Further review showed the resident was evaluated "after a physical assault from another resident at a nursing facility" and s/he was "...found to have an isolated hematoma to [his/her] right lateral thigh as well as CT and MRI imaging concerning possible discitis..." h. Review of an "ED Provider Note" for resident #2 dated 10/17/25 showed the resident was evaluated following an altercation with his/her roommate and the resident reported s/he "punched [his/her] roommate." Further review showed the "Clinical Impressions" included a "Closed nondisplaced fracture of the fifth metacarpal bone of right hand" and "abrasion of head." i. Interview with staff member #1 on 11/13/25 at 3:45 PM revealed she heard something in the room and when she walked in the room, she observed resident #1 on the	F0600		

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F0600 SS = G	Continued from page 3 ground and resident #2 standing over him/her. She revealed resident #1 was "screaming" for help. She revealed she removed the walker and observed resident #2 was bleeding, although she could not tell from where, and the blood was located from his/her temple to his/her ear. Further interview revealed nursing staff intervened and separated the residents. j. Interview with resident representative #1 for resident #1 on 11/13/25 at 1:50 PM revealed s/he had reported resident #1 was afraid of his/her roommate previously and heard resident #2 attacked another person "on Saturday." She revealed resident #1 was transferred from the emergency department to another facility due to a "blood infection that was affecting [his/her] spine" and s/he passed away on 10/29/25 at the hospital. k. Interview with resident representative #2 for resident #1 on 11/13/25 at 4:31 PM revealed the incident occurred after a visitor entered the residents' room and asked where resident #2 was. The representative said resident #1 told the visitor resident #2 was in the bathroom; however, the visitor did not hear him/her. The Representative revealed when resident #1 attempted to tell the visitor again, resident #2 became angry and started hitting resident #1 with a walker. The representative confirmed resident #1 was sent to the emergency room and then transferred to a different location. Further interview revealed law enforcement was notified and said there was not an immediate threat since resident #1 had been transferred. 2. Interview with the regional clinical director on 11/14/25 at 8:55 AM revealed the facility believed the resident to resident altercation between resident #1 and resident #2 was an isolated incident and as a result, resident #2 was placed in a room without a roommate. In addition, the facility had resident #2's medications reviewed and counseling was offered due to the resident reporting feeling down and depressed during a mini mental exam; however, the resident declined counseling at that time. The regional clinical director revealed resident #2 had an additional episode of aggression toward a staff member and the facility implemented an intervention for 2 staff members at all times when entering the resident's room. Following the incident of aggression toward staff, the resident was sent to the hospital for a psych evaluation; however, the resident did not qualify and was returned to the facility. 3. Review of the policy titled "Abuse, Neglect and	F0600		

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F0600 SS = G	Continued from page 4 Exploitation" dated 2025 showed "…1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property…" 4. Review of the post incident interventions showed the facility implemented the following corrective actions: a. Resident #1 and resident #2 were separated following the incident and each were went to the hospital for evaluation and treatment on 10/27/25. b. Upon return from the hospital on 10/17/25, resident #2 was placed in a room, without a roommate. c. Resident #1 did not return to the facility. d. Staff education on abuse was performed on 10/20/25. e. Facility audits were initiated to monitor resident redirection and de-escalation on 10/23/25. f. A QAPI meeting was performed and abuse was discussed on 10/20/25.	F0600		