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 01/15/2026

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 recertification survey was conducted by Healthcare Licensing and Surveys from 1/12/26 to 1/15/26. Also reviewed in the course of the survey were complaint intakes 2646748, 2648508, 2649795, 2663270, 2661073, 2710201, and 2712598. The following common abbreviations are used throughout this document. CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse	F0000		01/30/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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,	F0605	1) Immediate corrective action for affected residents(s): Resident #68's record was reviewed. The attending provider was notified and asked to clarify the clinical diagnosis and /indication /supporting the antipsychotic order and ongoing need. The diagnosis/indication /was clarified and updated in the medical record. The interdisciplinary team (IDT) reviewed current behaviors, non-pharmacologic interventions, risks/benefits, and potential adverse effects. Orders and the care plan were updated as /indicated, including Gradual Dose Reduction (GDR) considerations unless clinically contraindicated. 2) Identify other residents at risk: All Residents could be at risk. The facility completed an audit of all residents currently receiving antipsychotics and/or other psychotropic medications to verify: a) documented diagnosis/indication in the medical record b) behavior documentation supporting use	02/11/2026

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

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 01/15/2026

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
F0605 SS = D	Continued from page 1 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)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure	F0605	Continued from page 1 c) non-pharmacologic interventions attempted d) GDR documentation (when applicable) e) PRN psychotropic compliance with 14-day limitations, including documentation supporting continuation if applicable 3) Systemic changes to prevent recurrence: Implemented a Monthly Psychotropic/Antipsychotic Review Meeting for new starts, dose changes, renewals, and PRN continuation requests to ensure provider documentation of diagnosis/indication /is present prior to continuation. Updated the medication entry process so nursing/clinical management verifies diagnosis/indication /and care plan linkage prior to entering or continuing psychotropic medications. Completed in-service education on 1/22/26 for licensed nurses and IDT on psychotropic requirements /including /documentation, monitoring, behavioral interventions, GDR process, and PRN limitations. 4) Monitoring/audits: QAPI approved remedy on 2/5/2026 that beginning 02/11/2026, the DON or designee will audit 15 residents' weekly audits for four (4) weeks, then 15 residents monthly for two (2) months. Audit will verify: provider-documented diagnosis/indication documentation of non-pharmacological interventions and/or clinical contraindication evidence of informed consent (as applicable) care plan accuracy and linkage	

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 01/15/2026

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
F0605 SS = D	Continued from page 2 that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: 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	F0605	Continued from page 2 ongoing monitoring documentation Any identified concerns will result in corrective action, including provider notification, documentation correction, and staff re-education. Audit results will be reported to QAPI monthly. QAPI will /monitor /ongoing compliance until substantial compliance is achieved.	

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 01/15/2026

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
F0605 SS = D	Continued from page 3 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.	F0605		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility	F0637	1) Immediate corrective action for affected resident(s): Resident #32's record was reviewed. The MDS	02/11/2026

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 01/15/2026

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
F0637 SS = D	Continued from page 4 determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: 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."	F0637	Continued from page 4 Coordinator /initiated /and completed the required Significant Change in Status Assessment (SCSA) and updated the care plan to reflect post-hospice needs, services, and goals. Documentation corrected to reflect hospice revocation/discharge date and payer source changes as applicable. 2) Identify other residents at risk: All residents coming on and off hospice could be at risk. The facility completed an audit of residents with hospice election, revocation, discharge, and payer source changes to verify that SCSA assessments were completed within required /timeframes, /and supporting documentation was present. /Any discrepancies will be corrected 3) Systemic changes to prevent recurrence: Implemented a Hospice Change Trigger Process: hospice election, revocation/discharge, or /expiration /of terminal certification automatically triggers an MDS/IDT review task at the weekly PDPM meeting. Business Office and MDS implemented a same-day communication workflow for hospice status changes and payer updates to ensure MDS triggers are not missed. On 1/22/2026 a rapid in service was provided to Business Office, Social Services, Nurse Management, and MDS on /significant change /assessment requirements for hospice revocation/discharge. 4) Monitoring/audits: QAPI approved remedy on 2/5/2026 that beginning 02/11/2026, the DON or designee will audit all hospice residents weekly for four weeks, then monthly for two (2) months to ensure that SCSA assessments were completed within /14 days /of hospice discontinuation/revocation. The audit will verify: Business Office notified MDS within 24 hours	

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 01/15/2026

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
F0637 SS = D		F0637	Continued from page 5 MDS initiated the SCSA within required /timeframes ARD was set according to CMS RAI Manual guidelines Results and corrective actions will be documented using a measurement tool and reported to QAPI monthly. QAPI will /monitor /ongoing compliance until substantial compliance is achieved.	
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: 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.	F0693	1) Immediate corrective action for affected resident(s): Resident #62 was assessed on 2/4/2026 by licensed nurse to verify placement of peg tube and assessed for complications including aspiration risk, respiratory status, no complications were identified. E nteral feeding orders, care plan, and policy were reviewed including the verification of placement per protocol, checking residual per physician order/facility protocol, and /maintaining /HOB elevation at 30–45° during feeding and for at least one (1) hour after. 2) Identify other residents at risk: All residents with eternal feeding tube could be at risk. The DON or designee reviewed residents receiving tube feedings to ensure: a) orders include clear directions for residual checks and placement verification b) care plans reflect current feeding tube needs and aspiration precautions 3) Systemic changes to prevent recurrence: Re-educated licensed nurses on 1/22/2026 a rapid in service on feeding tube policy and physician order requirements, including placement verification, residual checks, and HOB elevation. SDC to complete competency validation on tube feeding administration for all licensed nurses.	02/11/2026

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 01/15/2026

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
F0693 SS = D	Continued from page 6 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.	F0693	Continued from page 6 4) Monitoring/audits: QAPI approved remedy on 2/5/2026 that beginning 02/11/2026, DON or designee will do direct observation audits for tube feeding to ensure nurse verified placement, residual check and HOB elevation. Audit will include 5 observations weekly x 4 weeks and then 5 observations monthly x 2 months. Any failed audit will result in immediate corrective action, re-education. Audit results will be reported to QAPI monthly.	
F0729 SS = D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(e)(4)-(6) §483.35(e)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation	F0729	No residents were identified; Staff Member 2's registry was sent into Wyoming C.N.A Registry on 1-15-2026 All Residents could be affected. HR Director Audited all current C.N.A. on 1-19-2026 and updated Wyoming C.N.A Registry as needed Administrator educated Hr. Director on 1-15-2026 Wyoming C.N.A Registry and that registry verification had to be completed prior to hire. Administrator or designee will audit all new hires weekly for 12 weeks to ensure compliance with regulation. Audits will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	02/11/2026

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 01/15/2026

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
F0729 SS = D	Continued from page 7 program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(e)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(e)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is NOT MET as evidenced by: 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.	F0729		
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F0756	1) Immediate corrective action for affected resident(s): The facility reviewed January monthly pharmacist drug regimen review (DRR) documentation and ensured all pharmacist recommendations were reviewed with the prescriber and IDT. For Resident #5, the pharmacy recommendation and /subsequent /dose change history were reviewed with the prescriber, the provider documented rationale and plan of care in the medical record.	02/11/2026

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 01/15/2026

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
F0756 SS = E	Continued from page 8 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: 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.	F0756	Continued from page 8 2) Identify other residents at risk: All residents could be at risk. The facility audited all resident recommendation reports for the last two months for irregularities or recommendations in the prior review period to ensure: a) provider review occurred b) action was taken OR rationale for no change was documented c) care plan and monitoring were updated as appropriate 3) Systemic changes to prevent recurrence: Implemented a monthly DRR review meeting with the Pharmacist Consultant, Nurse Management and Psych NP (as applicable) Implemented a standardized DRR tracking tool to ensure all irregularities/recommendations /are /received, reviewed, signed, addressed, and filed. DRR documentation will be /maintained /in a designated binder and electronically as applicable. Nurse management will verify completion of provider responses. 4) Monitoring/audits: QAPI approved remedy on 2/5/2026 that beginning 02/11/2026, the DON or designee will complete an audit of 15 residents Pharmacy Recommendations monthly x 3 months to ensure provider review/documentation was completed and orders implemented in PCC as appropriate. Results will be reported to QAPI and the Medical Director monthly. Any missing provider response will result in immediate provider follow-up and documentation correction.	

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 01/15/2026

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
F0756 SS = E	Continued from page 9 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..."	F0756		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761	1) Immediate corrective action: The insulin that was not dated was disposed of immediately during the survey process. All insulin multidose vials/pens were checked /immediately /to ensure that they were labeled with open date and discard date per /manufacturer's /guidance. Any insulin with unknown open date was discarded and replaced per policy. 2) Identify other residents at risk: A house-wide audit was completed /by licensed nurse on	02/11/2026

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 01/15/2026

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
F0761 SS = E	Continued from page 10 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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).	F0761	Continued from page 10 or before 2/11/2026 of all medication carts, treatment rooms, and medication refrigerators for multidose vials/pens requiring open-date labeling, and insulin found missing open date will be discarded and replaced per policy 3) Systemic changes to prevent recurrence: SDC or designee educated licensed nurses on multidose vial/pen labeling requirements, discard /timelines /and cart check process. Added standardized “Open Date / Discard Date” labels to all carts and medication storage areas. Implemented a medication cart check process requiring the nurse assigned to the cart to verify multidose vial/pen labeling at the start of each shift. 4) Monitoring/audits: QAPI approved remedy on 2/5/2026 that beginning 02/11/2026, DON or designee will audit 1 medication cart for unlabeled insulin multidose vials/pens. Audit will be completed 3times/weekly for 4 weeks /then 3 times/monthly for 2 months Any noncompliance will result in immediate corrective action, including discarding improperly labeled vials and re-education of staff. Results will be reported to QAPI monthly.	
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812	Hand hygiene and glove changes in kitchen	02/11/2026

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 01/15/2026

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
F0812 SS = E	Continued from page 11 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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. Cook #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. Cook #1 opened cooler #1 and retrieved a plastic	F0812	Continued from page 11 1) Immediate corrective action: Dietary staff were educated on hand hygiene requirements, glove changes, and cross-contamination prevention during food preparation on 1/22/2026 2) Identify other residents at risk: All Residents could be at Risk 3) Systemic changes to prevent recurrence: SDC educated Dietary staff on 1/22/2026 on requirements for hand hygiene and glove uses in the dietary department. Dietary manager verified availability of gloves and handwashing supplies. Education on dietary hand hygiene/glove change expectations was added to orientation and annual competency for dietary staff. 4) Monitoring/audits: QAPI approved remedy on 2/5/2026 that beginning 02/11/2026, Dietary Manager or designee will complete Audit to include 5 observations to ensure hand hygiene completed and glove use is appropriate. Audit will be completed weekly x 4 weeks then monthly x 2 months. Results will be reported to QAPI monthly. Any noncompliance will result in immediate corrective action and re-education.	

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 01/15/2026

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
F0812 SS = E	Continued from page 12 container of shredded cheese and proceeded to make individual salads. Cook #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. Cook #1 continued in the same manner and prepared a second tray of 12 bowls of salad. Cook #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 § 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."	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	1) Immediate corrective action: Staff involved were educated /on 1/22/2026 /on standard precautions and safe food handling practices during dining /assistance, including hand hygiene and glove/utensil use. 2) Identify other residents at risk:	02/11/2026

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 01/15/2026

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
F0880 SS = D	Continued from page 13 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F0880	Continued from page 13 The Infection Preventionist completed 5 meal dining observations to verify staff compliance with hand hygiene and appropriate resident food handling. No other residents were identified to be affected during observations. 3) Systemic changes to prevent recurrence: SDC educated CNAs and nursing staff on dining /assistance /infection control practices (hand hygiene before glove use; gloves or utensils /required /when handling resident food). infection control expectations including safe food handlings, and hand hygiene was added all staff orientation and annual training 4) Monitoring/audits: QAPI approved remedy on 2/5/2026 that beginning 02/11/2026, DON or designee to complete 5 dining meal observations to verify appropriate food handling. Audit will be completed 5xweekly x 4 weeks then 5 times monthly for 2 months. Any noncompliance will result in immediate corrective action, re-education, and repeat observation. Results will be reported to QAPI monthly.	

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 01/15/2026

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
F0880 SS = D	Continued from page 14 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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.	F0880		