STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 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
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 10/1/17 through 10/4/17. Also reviewed in the course of the survey were complaint intakes #WY00002334, #WY00002351, #WY00002354, #WY00002417, #WY00002429, #WY00002474, and #WY00002488. The following common abbreviations are used throughout the document: CDM: Certified Dietary Manager CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 167 SS=E	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 167		10/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/27/2017

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.

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F 167	Continued From page 1 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect confidential identifying information in regard to resident names for 3 of 3 years reviewed (2014, 2015, 2016) in the survey binder which was available for public viewing. The findings were: 1. Observation on 10/2/17 at 9:35 PM of the facility survey activity binder located near the main entrance showed the binder contained the "confidential for facility use only" resident sample list which listed resident names and corresponding identification numbers. The following concerns were identified: a. Review of the 4/23/14 survey showed the confidential resident sample list contained 30 resident names and identifying numbers. b. Review of the 8/1/14 survey showed the confidential resident sample list contained 45 resident names and identifying numbers. c. Review of the 10/17/14 survey showed the confidential resident sample list contained 25 resident names and identifying numbers. d. Review of the 3/19/15 survey showed the	F 167	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. F167 1. Resident Sample list from 2014, 2015 and 2016 was removed immediately on 10/02/2017. 2. The Director of Nursing or designee reviewed all posted surveys to validate the	

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F 167	Continued From page 2 confidential resident sample list contained 11 resident names and identifying numbers. e. Review of the 2/5/16 survey showed the confidential resident sample list contained 14 resident names and identifying numbers. f. Review of the 11/7/16 survey showed the confidential resident sample list contained 13 resident names and identifying numbers. g. Review of the 11/10/16 survey showed the confidential resident sample list contained 4 resident names and identifying numbers. h. Review of the 12/8/16 survey showed the confidential resident sample list contained 48 resident names and identifying numbers. 2. Interview on 10/2/17 at 9:45 PM with the DON confirmed the presence of these documents and at that time the DON removed them from the binder.	F 167	Resident Sample List were removed on or by 10/27/2017. 3. The Director of Nursing or designee was educated on 10/02/2017 to validate that the Resident Sample List is not posted for public viewing. The Director of Nursing or Designee will randomly review the posted surveys for public view after every HLS survey to validate the resident sample list is omitted. 4. The Director of Nursing or designee will report the tracking and trending of the random review to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 208 SS=B	483.15(a)(1)-(7) PROHIBITING CERTAIN ADMISSION POLICIES (a) Admissions policy. (1) The facility must establish and implement an admissions policy. (2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare	F 208		10/27/17

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F 208	Continued From page 3 or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. (3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. (4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic	F 208		

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F 208	Continued From page 4 contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. (5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. (6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. (7) A nursing facility that is a composite distinct part as defined in § 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on review of the facility's admission agreement and staff interview, the facility failed to ensure admission agreements did not request or require residents to waive potential facility liability for losses of personal property for 5 of 6 sample residents (#3, #14, #47, #65, #94) admitted after 11/28/16. The findings were: 1. Review on 10/4/17 at 10 AM of the facility's admission agreement, under section 11: Elections and Designations, last published 3/29/16 showed	F 208	F208 1. Resident #3, #14, #47, #65 and #94 have admission agreements that do not request or require residents to waive potential facility liability for losses of personal property. 2. The Admissions Director or designee will complete an audit of all admissions since 11/28/2016 to validate the new admission have an admission agreement	

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F 208	Continued From page 5 section 11.7 "Laundry Services. The Center provides residents with laundry services...The Resident Group understands that the Center may lose or damage the Resident's clothing and the Resident Group agrees that the Center is not responsible for such loss or damage, except as required by law." Further review showed the resident or resident representative was asked to initial whether to "Authorizes the Center to clean and mark with the Resident's name the Resident's laundry. The Center will not be responsible for lost or damaged laundry, except as required by law..." or "Do not authorize the Center to clean the Resident's laundry..." The following concerns were identified: a. Review of resident #3's 7/6/17 quarterly MDS assessment showed the resident was admitted to the facility on 3/30/17. Review of section 11.7 of the resident's admission agreement showed the resident initialed the section which authorized the facility to provide laundry services. b. Review of resident #14's 9/26/17 quarterly MDS assessment showed the resident was admitted to the facility on 3/21/17. Review of section 11.7 of the resident's admission agreement showed the resident initialed the section which authorized the facility to provide laundry services. c. Review of the resident #47's 9/6/17 quarterly MDS assessment showed the resident was admitted to the facility on 1/20/17. Review of section 11.7 of the resident's admission agreement showed the resident initialed the section which authorized the facility to provide laundry services. d. Review of resident #65's 8/18/17 quarterly MDS assessment showed the resident was admitted to the facility on 5/16/17. Review of	F 208	that does not request or require the resident to waive potential facility liability for losses of personal property. 3. The Admissions Director or designee was educated on 10/19/2017 regarding the facility admission agreement and that the facility does not request or require residents to waive potential facility liability for losses of personal property. The Facility Admission Agreement was revised and is in effect on or before 10/27/2017 for all new admissions to validate it does not request or require the resident to waive potential facility liability for losses of personal property. 4. The Admissions Director or designee will report any changes to the admission agreement to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained by the committee.	

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F 208	Continued From page 6 section 11.7 of the resident's admission agreement showed the resident's representative initialed the section which authorized the facility to provide laundry services. e. Review of resident #94's 8/31/17 annual MDS assessment showed the resident was admitted to the facility on 4/14/17. Review of section 11.7 of the resident's admission agreement showed the resident's representative initialed the section which authorized the facility to provide laundry services. 2. Interview on 10/4/17 at 10:10 AM with the admissions coordinator verified she used the admission agreement when admitting a new resident, however, she was unable to explain what the section that stated "The Center will not be responsible for lost or damaged laundry, except as required by law" meant.	F 208		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure	F 225		10/27/17

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F 225	Continued From page 7 body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the	F 225		

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F 225	Continued From page 8 administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on employee file review and staff interview, the facility failed to ensure pre-hire screening was completed for 2 of 2 employees (CNA #1, CNA #2). The findings were: 1. Review of the employee file for CNA #2 showed a 8/30/17 hire and start date. Further review showed no documentation to determine if the CNA registry was checked from hire to the survey timeframe of 10/1/17 to 10/5/17. 2. Review of the employee file for CNA #1 showed a 8/16/17 hire and start date. Further review showed no documentation to determine if the CNA registry was checked from hire to the survey timeframe of 10/1/17 to 10/5/17. 3. Interview with the administrator on 10/5/17 at 10 AM revealed it was her expectation for staff to check the CNA registry prior to hiring CNAs, and confirmed the facility failed to document this process was completed for CNAs #1 and #2.	F 225	F225 1. CNA #1 and CNA#2 were screened on the HLS CNA registry on or before 10/27/2017. 2. The Business Office Manager or designee will complete an audit of CNAs to ensure CNAs have been screened on the HLS CNA registry on or by 10/27/2017. 3. The Business Office Manager or designee was educated to validate CNAs are screened on the HLS registry prior to direct patient contact on 10/04/2017. 4. The Business Office Manager or designee will complete a weekly audit of newly hired CNAs for 60 days to validate CNAs are screened on the HLS registry prior to direct patient contact. The Business Office Manager or designee will report tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 244	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP	F 244		10/27/17

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F 244 SS=E	Continued From page 9 GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview, review of policy and procedures, and grievance log, the facility failed to effectively act on grievances for 4 of 4 months reviewed (June, July, August, September of 2017) to improve handling of resident's personal laundry. The findings were: Observation of the laundry room on 10/4/17 at 10:51 AM revealed there was a portable laundry rack in the laundry room which contained clothing whose ownership was not identifiable due to not being labeled or the labeling was too faded. Interview at that that time with facility laundry manager #1 revealed they "let the cart fill up" then "every couple of months" the clothing rack was brought to the resident floors to see if the clothing could be identified by staff, residents or family members. Clothing not identified was discarded. The laundry room had a heat press to affix	F 244	F244 1. Residents with laundry grievances in June, July, August and September have had their laundry checked and clearly name labeled on or before 10/27/2017. 2. The Environmental Services Director or designee will validate residents clothing have been checked and clearly name labeled on or before 10/26/2017. 3. Facility staff to be educated on or before 10/27/2017 to validate residents clothing is clearly name labeled. 4. The Environmental Services Director or designee will audit laundry grievances weekly for 90 days to validate residents clothing is clearly name labeled.	

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F 244	Continued From page 10 permanent labels to clothing. Staff indicated that this was used when nurses sent laundry that specifically needed a label affixed, such as dark clothing where markers would not show. Further,the laundry manager stated there were markers specifically made to withstand high heat up to 500 degrees, however, these were not commonly used by the nurses. He confirmed the regular sharpie markers used by staff to mark clothing was "not ideal" and lasted only 3-4 months. Review of grievance logs for June 2017 through September 2017 showed complaints laundry was not returned within 72 hours. These complaints included 5 of 12 laundry grievances in June, 12 of 19 laundry grievances in July, 13 of 22 laundry grievances in August 2017, and 10 of 22 laundry grievances in September 2017. Two instances occurred in August and September 2017, where items were not located and reimbursement was offered. Interview with a family member on 10/4/17 at 11:04 AM revealed she was frustrated with the facility's laundry service. S/he revealed s/he ironed on identification labels which had been lost in the laundry. Interview on 10/4/17 at 10:55 AM with the social services staff revealed the facility's standard turn around time for clothing being laundered was 72 hours. She stated the facility has attempted to educate residents about the turn around time to lessen the amount of grievances. Further, she confirmed when residents were admitted to the facility, nurses use a standard "Sharpie" marker to mark resident's clothing.	F 244	The Environmental Services Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 244	Continued From page 11 Interview on 10/4/17 at 11:27 AM with RN #2 revealed nurses marked all clothing and filled out an inventory sheet of personal items when residents were admitted. She stated nurses used a "regular old sharpie" to mark the clothing, unless it was dark clothing, in which case a label was affixed, after asking the resident or family it it was OK to be done. She stated "most everybody just stops and lets you know" if new clothing was brought into the facility. Interview on 10/4/17 at 1:29 PM with the administrator revealed the facility had provided education to residents regarding the facility policy of a 72 hour turn around time for laundry. She stated the facility called family to bring in more clothes when it was noticed a resident didn't have enough of a supply of clothing. She confirmed that the facility holds a "shopping party" every "couple of months" where the rack of unidentified clothing was brought to the resident floors to see if the clothing could be identified by staff, residents or family members. Review of policy and procedure for processing resident personal clothing showed "All clothing for residents must be labeled in a manner that is both practical and respects the dignity of the resident,. A small, permanent tag or label with the resident's name, placed in an inconspicuous place on each article of clothing, is key." It further stated "Follow-up is needed to ensure that any clothing brought in by families for holidays or birthdays is also labeled properly before going to the resident's unit. Additionally, assigned staff needs to remember to check for lost labels or faded writing on a regular basis."	F 244		
F 253	483.10(i)(2) HOUSEKEEPING & MAINTENANCE	F 253		10/27/17

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F 253 SS=E	Continued From page 12 SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean and sanitary environment on 3 of 3 floors (1st floor, 2nd floor, 3rd floor) and failed to maintain one randomly observed resident's wheelchair (#35) in a clean manner. The findings were: 1. Observation on 10/3/17 at 10:02 AM showed the horizontal molding at a 12 inch height in the hallway of the third floor was visibly dusty, this was noted near rooms 302, 314, 316, and 319. Observation at 10:41 AM showed the horizontal molding at a 12 inch height in the hallway of the second floor was visibly dusty, near rooms 224, 225, 226, and 227. Further observation at 11:18 AM showed the horizontal molding at a 12 inch height in the hallway of the first floor was visibly dusty, near rooms 113 and 114. 2. Observation on 10/1/17 at 4:38 PM showed resident #35 sitting in a wheelchair in the second floor hallway. The wheelchair had visible debris and dirt on the wheelchair wheel spokes and brake system. There was an unidentified green substance stuck to the brake system as well. Further observation on 10/4/17 at 11:35 AM showed the same resident sitting at a table in the dining room. The wheelchair was noted as having debris and dirt on the wheels and brake system, and the green substance noted on 10/1/17 remained stuck to the brake system.	F 253	F253 1. Horizontal Molding in hallway near room #302, #314, #316, #319, #224, #225, #226, #227 #113 and #114 was cleaned of dust on or by 10/27/2017. Resident #35 wheelchair was cleaned on 10/05/2017. Invacare Reliant RPS 350 sit to stand on the 2nd floor was cleaned on 10/05/2017. Invacare Platinum 10 oxygen concentrator in Room 224 was cleaned on 10/06/2017. 2. The Environmental Services Director or designee will complete an audit on or before 10/27/2017 of Horizontal molding in hallways to validate they are cleaned of dust. The Director of Nursing or designee will complete an audit of resident wheelchairs, sit to stand lifts and oxygen concentrators to validate they are cleaned on or by 10/27/2017. 3. Staff Development Coordinator or designee to educate Nursing Department Staff on or by 10/27/2017 to ensure resident wheelchairs, sit to stand lifts and oxygen concentrators are cleaned	

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F 253	Continued From page 13 3. Observation on 10/3/17 at 10:26 AM showed an "Invacare Reliant RPS 350" sit-to-stand lift, located on the second floor, had flaky, light-colored particles covering the footboard. Observation of the same lift on 10/4/17 showed the footboard to be in the same condition. 4 .Observation on 10/4/17 at 9:42 AM showed an "Invacare Platinum 10" oxygen concentrator in room 224 had a cabinet air filter visibly covered in dust. 5. Interview on 10/4/17 at 11:38 AM with housekeeping staff #1 revealed the janitorial staff was primarily responsible for the cleaning of the hallway floors and surfaces, and it was not a regular part of the housekeeping routine. 6. Interview on 10/4/17 at 11:30 AM with RN #2 revealed staff was expected to clean lifts after every use, wiping the surfaces with bleach wipes. She further confirmed that none of the lifts were for single resident use. 7. Interview on 10/4/17 at 11:48 AM with the DON revealed wheelchairs were supposed to be cleaned on each resident's shower day, and the task was performed by hospitality aides on the evening shift. She confirmed resident #35's wheelchair did not appear to have been recently cleaned. She further confirmed the "Invacare Reliant RPS 350" sit-to-stand lift was not clean and the expectation was for equipment including lifts to be cleaned after every use. Finally, she concurred the horizontal molding in the hallway was dusty and required cleaning.	F 253	regularly. 4. The Director of Nursing or designee will randomly audit five (5) resident wheelchairs and one (1) sit to stand lifts three (3) times per week and 10 oxygen concentrators per week for 60 days to validate they are free of dirt and debris. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		10/27/17

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F 278	Continued From page 14 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the Resident Assessment Instrument User's Manual, and staff interview, the facility failed to ensure the	F 278	F278 1. The MDS Coordinators were educated on 10/04/2017 regarding	

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F 278	Continued From page 15 MDS assessment was certified as complete in a timely manner for 9 of 18 sample residents (#9, #17, #23, #36, #47, #64, #65, #83, #90). The findings were: Review of timeliness criteria in "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14" (section 5.2), by the Centers of Medicare and Medicaid Services, showed the MDS completion date (item Z0500B) must be no later than the 14th calendar day of the resident's admission for an admission assessment and no later than the assessment reference date (ARD) plus 14 days for an annual assessment. For a significant change assessment, the completion date must be no later than 14 days after the determination that a significant change has occurred. The following concerns were identified: 1. Review of the admission MDS assessment, with an ARD of 5/23/17, revealed resident #65 was admitted on 5/16/17. Further review of section V showed the RN certified the assessment as being complete on 6/8/17 (the 23rd day after admission). 2. Review of the annual MDS assessment for resident #83 revealed an ARD of 3/31/17. Review of section V showed the RN had not certified the assessment as being complete until 4/17/17 (17 days after the ARD). 3. Review of the annual MDS assessment for resident #64 revealed an ARD of 10/20/16. Review of section V showed the RN had not certified the assessment as being complete until 11/16/17 (28 days after the ARD). Review of the significant change MDS assessment with an ARD	F 278	certifying and completing the MDS assessment timely. 2. The MDS Coordinator or designee will complete an audit of open MDS assessments to validate the MDS assessment is certified as complete in a timely manner on or by 10/27/2017. 3. The MDS Coordinator or designee will complete a weekly audit for 60 days of MDS assessments to validate the MDS assessment is certified as complete in a timely manner. 4. The MDS Coordinator or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 278	Continued From page 16 of 6/21/17 for the same resident showed it was not certified as complete until 7/11/17 (20 days after the ARD). 4. Review of the significant change MDS assessment for resident #23 showed an ARD of 5/16/17. Further review revealed the RN failed to sign the assessment as complete on section Z until 6/8/17 (23 days after the ARD). 5. Review of the annual MDS assessment for resident #17 showed an ARD of 12/22/16. Further review revealed the RN failed to sign the assessment as complete on section Z until 2/20/17 (60 days). 6. Review of the significant change MDS assessment for resident #9 showed an ARD of 1/20/17 and a completion date of 2/23/17 (34 days after the ARD). Review of the significant change MDS assessment for resident #9 showed an ARD of 8/22/17 and a completion date of 9/18/17 (27 days after the ARD). 7. Review of the annual MDS assessment for resident #90 showed an ARD of 1/18/17. Further review revealed the RN failed to sign the assessment as complete on section Z until 2/27/17 (40 days). 8. Review of the admission MDS assessment for resident #36 showed an ARD of 1/19/17. Further review revealed the RN failed to sign the assessment as complete on section Z until 2/20/17 (23 days). 9. Review of the admission MDS assessment for resident #47 showed an ARD of 1/20/17. Further review revealed the RN failed to sign the	F 278		

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F 278	Continued From page 17 assessment as complete on section Z until 2/20/17 (22 days). 10. Interview on 10/4/17 at 9:55 AM with the MDS coordinator revealed she was aware of the 14 day completion deadline and verified the MDS assessments were not completed within the correct timeframe.	F 278		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		10/27/17

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F 309	Continued From page 18 (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff, family, and hospital case manager interviews, and policy and procedure review, the facility failed to ensure physician orders were followed in a timely fashion and nursing care was provided in accordance with professional standards of practice for 1 of 1 residents (#113) who had a significant change in condition. This failure resulted in delayed treatment and further decline in condition that required transport to the emergency room. In addition, the facility failed to ensure effective pain management for 1 of 7 sample residents (#114) who were assessed as needing pain management to help maintain his/her highest practicable level of well-being. This failure resulted in a decline in health status and inability to participate in activities and bedside therapy. The findings were: 1. Review of the medical record for resident #113 showed an admission date of 9/2/15 with a discharge date of 2/23/17. The resident had diagnoses which included muscle weakness, history of falling, essential hypertension, atherosclerotic heart disease of native coronary artery, asthma and other specified disorders of nose and nasal sinuses. The following concerns were identified: a. An interdisciplinary progress note dated 2/19/17 and timed 12:30 AM noted the resident	F 309	F309 1. Resident #113 discharged on 02/23/2017. Resident #114 discharged on 09/05/2017. 2. The Director of Nursing or designee completed an audit of residents with a change of condition to validate residents with a change of condition to ensure residents with a change of condition are monitored every shift and treatment is provide timely as ordered by the physician. The Director of Nursing or designee completed an audit of resident□s pain to validate their pain is adequately controlled per the residents□ plan of care. 3. The Staff Development Coordinator or designee re-educated facility nurses to validate resident change of condition is being monitored every shift and treatment is provided timely as ordered by the physician and to re-educate facility nurses to validate resident□s pain is adequately controlled per the residents□ plan of care. 4. The Director of Nursing or designee will complete an audit 5 days a week for two(2) weeks, three (3) times per week for	

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F 309	Continued From page 19 had a pulse of 89 beats per minute (bpm), an oxygen saturation level of 86%, and "expiratory wheeze noted in RLL [right lower lung] and LLL [left lower lung], more significant wheeze in LLL. Audible crackles without stethoscope [sic]. Resident displays/reports no SOB [shortness of breath]. Asked resident to deep breathe and cough multiple times. Resident attempted each time but struggled to produce a productive cough. Resident is in no acute distress...left resident in bed in the lowest position, to go back to sleep. Will continue to monitor." Further review of progress notes showed the next entry was dated three days later, on 2/22/17 and timed 2 PM, and showed the resident was started on Duonebs (an inhalation solution that dilates lung cells) every 6 hours for 5 days and Azithromycin (an antibiotic) for 5 days with a diagnosis of upper respiratory infection. No evidence was provided to show the resident was assessed during the three days between progress notes, or that the resident's signs/symptoms were addressed prior to 2/22/17. b. Review of an SBAR communication form showed the medical doctor was notified of the resident's condition on 2/19/17 at 4:15 AM by fax. A faxed response dated 2/20/17 showed an order for Duoneb (a breathing treatment) every six hours for five days, and Azithromycin (an antibiotic) 250 milligrams, 2 tablets by mouth on the first day, followed by 1 tablet daily for 4 days. However, review of the medication administration record showed the resident did not receive either the Duoneb inhaler or the Azithromycin antibiotic until 2/22/17. c. Review of a progress note, dated 2/23/17 and timed 3:45 PM showed the resident had a pulse of 131 bpm and temperature of 101.1 Fahrenheit (F). d. Review of the progress note dated 2/24/17	F 309	two(2) weeks, then weekly times one (1) month of residents□ having a change of condition to validate the resident is being monitored every shift and treatment is provided timely as ordered by the physician. The Director of Nursing or designee will complete an audit 5 days a week for two(2) weeks, three (3) times per week for two(2) weeks, then weekly times one (1) month of residents□ pain to validate their pain is adequately controlled per the residents□ plan of care. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 309	Continued From page 20 and timed at 4 AM showed the resident had a pulse of 124, temperature of 101.6 F and oxygen saturation of 87% on 3L (liters of oxygen). The note showed the resident was short of breath and sweating. The note further showed the doctor had contacted the facility, and thought the resident may have had pneumonia and may have been going septic, and ordered for the resident to be transferred to the hospital for evaluation and treatment. The resident was transferred to the emergency department on 2/24/17. e. Interview on 10/4/17 at 3:02 PM with the DON revealed the facility had reviewed the charting and assessments for resident #113 and confirmed it was not sufficient. The DON stated the nurse who had made the progress note entry on 2/19/17 "was new" and had not placed the resident on alert charting for follow up from her assessment. The facility provided education to staff on 3/8/17 regarding charting requirements. f. Review of inservice education attendance sheets dated 3/8/17 indicated education was provided to staff which included 24 hour documentation. Handouts included the facility policy for "Alert Charting Guidelines" which stated the following for upper and lower respiratory infections: "Alert charting Q (every) shift until condition improves or resolves. Vital Signs Q shift - Allow to sleep on 3rd shift unless condition warrants interruption. Lung sounds Q shift or as condition warrants. Characteristics of sputum. Activity tolerance. Oxygen use, Oxygen saturation. Dietary tolerance, fluid intake." For exacerbation of cardiac/respiratory condition, the guideline stated "Alert charting Q shift. VS Q shift. Heart & lung sounds. Circulatory changes, edema. Daily weight. Activity tolerance. Oxygen use, oxygen saturations. Medications: response to, side effects."	F 309		

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F 309	Continued From page 21 2. Review of the medical record showed resident #114 was admitted from the hospital on 8/24/17 and diagnoses included intractable low back pain, chronic kidney disease and chronic obstructive lung disease. Further review showed at the hospital the resident's pain was effectively managed with a Lidocaine patch, Fentanyl patch, and Norflex (all are medications for pain). Review of the nursing admission assessment revealed the resident did not have cognitive impairment and required assistance with toileting and transfers. This review also revealed the resident had "constant pain" in his/her lower back. Review of the physician admission orders showed orders for Percocet 10/325 milligrams (an opiod pain medication) every 4 hours as needed for pain. Review of nursing notes dated 8/30/17 showed the resident received a neuromuscular block injection in the lumbar area of the spine. According to the nursing notes the resident reported the procedure "greatly improved" the pain, but s/he continued to need the Percocet pain medication every 4 hours. Review of the physician orders, dated 8/31/17, showed an order to apply a Lidocaine transdermal patch to the lower back each day for lumbar stenosis pain. The following concerns were identified regarding ineffective pain management: a. Review of the narcotic book sign out sheet for the resident showed after receiving the daily Lidocaine patch the resident continued to need Percocet for pain. This review revealed 25 doses of Percocet were administered after the Lidocaine patch was started on 8/31/17 and before the facility obtained an order for a Fentanyl patch on 9/5/17 (5 days). b. Review of the nursing assessments before and after administering the pain	F 309		

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F 309	Continued From page 22 medication showed the medication was effective only for a short time. Interview with LPN #1 on 10/4/17 at 3 PM revealed the resident had a lot of pain and it was never completely controlled. The LPN stated the resident was unable to participate in a lot of activities and bedside therapy due to the pain. He further stated it was difficult to get the physician to prescribe additional medications. c. Interview with the hospital case manager on 10/9/17 at 9:10 AM revealed she visited the resident at the hospital prior to the transfer to the nursing home and was concerned when she saw the resident at the nursing home on 9/5/17 because there was a noticeable decline in health status and the resident complained of severe back pain. d. Interview with the family on 10/10/17 at 5:45 PM and again on 10/13/17 at 9:50 AM revealed the family visited 1 to 2 times daily and verbalized their concerns about the resident's pain to the nursing staff. During the interview the family member described the resident's pain as s/he "was always hurting" and the resident remained in bed most of the time due to the pain. e. Review of the admission and nutrition hydration status care plans, developed on 8/24/17, showed pain was an identified problem, but there were no documented interventions for this problem. The facility was unable to provide evidence of an individualized plan for managing the resident's pain, an initial pain assessment to establish desirable goals, and evaluation of this effectiveness of non-pharmacological approaches. f. Interview with the DON on 10/4/17 at 10:30 AM revealed staff talked with the physician about the resident's pain, but the physician was reluctant to prescribe different medications. Review of the documentation provided by the	F 309		

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F 309	Continued From page 23 facility revealed the nursing staff contacted the physician on 8/31/17 and 9/5/17 to report the pain medication was not effective. This review also revealed additional efforts to report the ineffective pain management to the physician and/or request for involvement from other practitioners were lacking g. Review of hospital records showed the resident was admitted on 9/5/17. Review of the hospital physicians progress note dated 9/11/17, revealed the resident had a "lumbar burst fracture with retropulsion causing severe canal stenosis and impinging conus". h. Review of Pain Management Policy -495, updated June 2016, showed the following procedures were included in the measures for effective pain management: When pain is not adequately controlled by current regiment, I, or if there is newly identified pain, the Licensed Nurse (LN) contacts the physician for consideration of new or modified treatment orders. The information on the Pain Evaluation Record is used in conjunction with the Center's other evaluation and data collection tools to develop an individualized care plan including non-pharmacological interventions, if appropriate.	F 309		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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	F 329		10/27/17

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GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 329	Continued From page 24 (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 that-- (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; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimen for 1 of 20 sample residents (#90) was free from unnecessary drugs. The findings were: 1. Review of the 7/18/17 quarterly MDS assessment showed resident #90 had severe cognitive impairment and diagnoses which	F 329	F329 1. Resident #90 received a risk versus benefits statement on 10/20/2017. 2. The Director of Nursing or designee will complete an audit on or before 10/27/2017 of July, August and September Pharmacy Recommendations to validate the Recommendations for	

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F 329	Continued From page 25 included anxiety, depression, bipolar disorder, and dementia. Review of the care plan, revised on 8/1/17, showed problems included dementia, feelings of depression, self isolation and verbal outbursts of screaming when ambulating or with cares. This review also showed interventions included interdisciplinary team and physician review for reduction of dosage every 3 months and report new behaviors, and worsening or violent behaviors. Review of the quarterly Psychoactive Drug and Behavior Medication Review Form, dated 6/20/17, showed the interdisciplinary team noted the resident had increased outbursts with agitation and anxiety. Review of the psychotherapy progress notes, dated 8/25/17, 9/1/17, 9/7/17, and 9/15/17 showed the resident reported "depressed mood daily, little to no interest in most things, and has feelings of worthlessness." Review of the physician's orders and October 2017 MAR showed buspar (anti-anxiety medication)15 milligrams (mg) 3 times a day was ordered on 3/1/16, guanfacine (for treatment of anxiety disorder) 1 mg 2 times a day was ordered on 3/7/15, aripiprazole (antipsychotic) 2 mg daily was ordered on 3/7/15 and venlafaxine ER (antidepressant) 225 mg daily was ordered on 4/12/17. Review of the Consultant Pharmacist Medication Regimen Reviews dated 2/13/17 - 2/21/17 and 9/25/17-9/26/17 showed the pharmacist recommended the physician review the medications for a gradual dose reduction and document a risk versus benefits rationale if the physician determined the reduction should not be done. Review of the pharmacy consultation report, dated 2/27/17, and the Psychoactive Drug and Behavior Medication Review Form dated 6/20/17 showed the physician response each time was for the medication review to be done by	F 329	residents on psychotropic drugs are free from unnecessary drugs. 3. The Staff Development Coordinator or designee will educate facility nurses on or before 10/27/2017 to validate Pharmacy Recommendations for unnecessary drugs are completed timely. 4. The Director of Nursing or Designee will complete a monthly audit for 60 days of Pharmacy Recommendations to ensure the recommendations for residents on psychotropic drugs are free from unnecessary drugs are completed timely. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 329	Continued From page 26 the psychiatrist. Interview with the DON on 10/4/17 at 11:10 AM revealed a psychiatrist was not available at the time the pharmacist made his initial recommendation. She further stated the review for the gradual dose reduction had not been done because they did not have a psychiatrist until September 2017.	F 329		
F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 356		10/27/17

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F 356	Continued From page 27 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the posted 24 nursing staff information was maintained and updated to reflect the correct number of staff and actual hours worked for 16 of 16 days. The following concerns were identified: 1. Review of the posted daily nursing staff information and review of the nursing master schedule dated 9/15/17 through 9/30/17 showed discrepancies in the actual number of nursing staff that were on duty. 2. Interview with the nurse scheduler on 10/4/17 at 1:55 PM confirmed the posted daily staffing schedule was not updated. She stated, "I post the sheet at the beginning of the day and on Friday evenings for the weekend. I don't update the numbers at the beginning of each shift, based on	F 356	F356 1. The Central Supply Coordinator or designee was educated on 10/04/2017 regarding timely and accurate posting of nursing staff information. 2. The Staff Development Coordinator or designee will educate facility nurses on or before 10/27/2017 to validate nursing staff information is posted timely and accurately. 3. The Central Supply Coordinator or designee will complete a five (5) times per week audit for 60 days to validate nursing staff information is posted timely and accurately. 4. The Director of Nursing or designee	

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F 356	Continued From page 28 actual staff on duty." She revealed the accurate staffing numbers are on her master nursing schedule. Both the nurse scheduler and DON stated they did not know the posted staffing sheets must be updated when staff numbers or hours changed.	F 356	will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of food temperature logs, and policies and procedures, the facility failed to ensure hot food	F 371	F371 1. The Food and Nutrition Services Manager or designee was educated on	10/27/17

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F 371	Continued From page 29 temperatures were at a safe level prior to service during observation of food service on 1 of 4 facility units. The findings were: Observation on 10/2/17 at 4:10 PM in the kitchen showed 2 small containers of pureed food were on the prep table and remained there until they were covered and placed on the delivery food cart at 4:55 PM. Cook #1 and the CDM made periodic observations of the pizza in the oven, the pureed food on the prep table, and the hamburger patties in the warmer without checking the temperature of the foods. At 4:30 PM Cook #1 and the CDM removed the cooked pizza from the oven, used a spatula to move individual slices into a serving pan, covered the pan and placed it on the food delivery cart. The cook removed the cooked hamburger patties from the warmer. He then removed the bowls of lettuce salad and sliced tomatoes from the cooler and placed them on the food delivery cart. Staff were observed performing the tasks with gloves and appropriate hand hygiene, however during the observation they did not check the temperature of the hot foods. Review of the food temperature log for this meal revealed it was blank. Continued observation revealed the food was wheeled to the nursing unit and nursing staff assisted the dietary staff in preparing the food items for service. The hot items including the pureed foods were placed on the steam table and the cold items in the iced pan that was set aside. Observation of the steam table revealed the gauges on the controls were worn making it impossible to know the temperature setting. At 5:30 PM the dietary aide donned gloves after	F 371	10/04/2017 regarding obtaining and documenting hot food temperatures prior to meal service. 2. The Food and Nutrition Services Manager or designee to educate Dietary Staff to ensure hot food temperatures are obtained and documented prior to meal service on or before 10/27/2017. 3. The Food and Nutrition Services Manager or designee will complete a one (1) meal per day five (5) times per week audit for 60 days to validate hot food temperatures are obtained and documented prior to meal service. 4. The Food and Nutrition Services Manager or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 371	Continued From page 30 hand hygiene and began to serve the food. Review of the food temperature log book for this meal revealed no documented food temperatures. Interview with the CDM on 10/2/17 at 5:45 PM revealed the policy required all dietary staff to ensure food items were at a safe temperature prior to meal service. He further stated he needed to provide additional staff education to ensure this is done consistently. Review of the Policy titled "Food Temperature Policy-785", dated December 2009, showed food temperatures were to be taken and documented daily prior to meal service.	F 371		
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (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. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 428		10/27/17

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F 428	Continued From page 31 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. (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 medical record review, pharmacy drug regimen review, and staff interview, the facility failed to ensure pharmacist recommendations were addressed for 8 of 16 sample residents (#3, #9, #17, #22, #64, #65, #82, #90). The findings were: 1. Review of the 8/28/17 to 8/29/17 Consultant	F 428	F428 1. Pharmacy Recommendation was followed through on or before 10/27/2017 for resident, #3, #9, #17, #22, #64, #65, #82 and #90. 2. The Director of Nursing or designee will complete an audit on or before	

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F 428	Continued From page 32 Pharmacist Medication Regimen Review for resident #3 showed the pharmacist recommended the resident's scheduled Synthroid 25 micrograms (mcg) be changed from being given in the AM to being given at 6 AM or at HS (bedtime) in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 medication administration record (MAR) showed the medication was being given between 6 AM and 10 AM. Further review of the medical record showed that the pharmacist recommendation had not been addressed. Continued review of the Consultant Pharmacist Medication Regimen Review showed the pharmacist noted that the resident's ordered eyedrops were scheduled to be given together. The eyedrop orders were for brimonidine 0.1% scheduled at HS (bedtime), timolol 0.5% scheduled at HS, and dorzolmide 2% scheduled at 8 AM, 2 PM, and 8 PM. The pharmacist made the recommendation to "separate administration of each eye drop by at least 3 to 5 minutes." Review of the October 2017 MAR showed the medications were not specified to be given separately with any interval between medications. Review of the medical record showed that the recommendation had not been addressed. 2. Review of the 8/28/17 to 8/29/17 Consultant Pharmacist Medication Regimen Review for resident #17 showed the pharmacist recommended that the resident's scheduled Synthroid 50 mcg be changed from being given in the AM to being given at 6 AM or at HS (bedtime) in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 MAR showed the medication was being given between 6 AM and	F 428	10/27/2017 of July, August and September Pharmacy Recommendations to validate the recommendations for residents are completed timely. 3. The Staff Development Coordinator or designee will educate facility nurses on or before 10/27/2017 to validate Pharmacy Recommendations for residents are completed timely. 4. The Director of Nursing or designee will complete a monthly audit for 60 days of Pharmacy Recommendations to validate the recommendations for residents are completed timely. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 428	Continued From page 33 10 AM. Review of the medical record showed that the recommendation had not been addressed. 3. Review of the 7/24/17 to 7/26/17, 8/28/17 to 8/29/17, and 9/25/17 to 9/26/17 Consultant Pharmacist Medication Regimen Reviews for resident #22 showed the pharmacist recommended that the resident's scheduled Flomax be changed from being given in the AM to being given approximately 30 minutes after the same meal each day since taking this drug on an empty stomach may increase risk of side effects such as blood pressure drop and dizziness. Review of the October 2017 MAR showed the medication was being given between 6 AM and 10 AM. Review of the medical record showed that the recommendation had not been addressed. Continued review of the Consultant Pharmacist Medication Regimen Review showed the pharmacist recommended on 9/26/17 that the resident's 1/22/17 order for Seroquel 50 mg (milligrams) be given in the AM and be considered for a GDR (gradual dose reduction). Review of the October 2017 MAR showed the medication dosage and administration time were not changed. Review of the medical record showed that the recommendation had not been addressed. 4. Review of the 7/24/17 to 7/26/17 and 8/28/17 to 8/29/17 Consultant Pharmacist Medication Regimen Review for resident #64 showed the pharmacist recommended the resident's scheduled Prilosec 20 mg be changed from being given in the AM to being administered approximately 30 minutes before the meal to achieve optimal therapeutic effect. Review of the October 2017 MAR showed the medication was	F 428		

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F 428	Continued From page 34 being administered between 6 AM and 10 AM. Review of the medical record showed the recommendation had not been addressed. Continued review of the Consultant Pharmacist Medication Regimen Review for 8/28/17 to 8/29/17 and 9/25/17 to 9/26/17 showed the pharmacist recommended the resident's scheduled Synthroid 25 mcg be changed from being given in the AM to being given at 6 AM or at HS in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 MAR showed the medication was being administered between 6 AM and 10 AM. Review of the medical record revealed the recommendation had not been addressed. 5. Review of the 8/28/17 to 8/29/17 and 9/25/17 to 9/26/17 Consultant Pharmacist Medication Regimen Review for resident #65 showed the pharmacist recommended the resident's scheduled Synthroid 50 mcg be changed from being given in the AM to being given at 6 AM or at HS in order to ensure the medication would be given on an empty stomach for optimal absorption. Review of the October 2017 MAR showed the medication was being administered between 6 AM and 10 AM. Review of the medical record showed the recommendation had not been addressed. 6. Review of the 8/28/17 to 8/29/17 and 9/25/17 to 9/26/17 Consultant Pharmacist Medication Regimen Review for resident #82 showed the pharmacist recommended the resident's scheduled Synthroid 25 mcg be changed from being given in the AM to being given at 6 AM or at HS in order to ensure the medication would be given on an empty stomach for optimal	F 428		

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F 428	Continued From page 35 absorption. Review of the October 2017 MAR showed the medication was being administered between 6 AM and 10 AM. Review of the medical record showed the recommendation had not been addressed. 7. Review of the Consultant Pharmacist Medication Regimen Review dated 9/25/17-9/26/17 showed Resident #9 had a prescription for Ativan since 6/17/17. Further review showed the resident had received zero doses in 4 months. The pharmacist recommendation was to provide a risk versus benefit assessment if the current therapy was to be continued. Interview on 10/4/17 at 11:30 AM with the DON revealed "The medication should have been discontinued but it hasn't been." 8. Review of the physician's orders and October 2017 MAR for resident #90 showed Buspar (anti-anxiety medication)15 milligrams (mg) 3 times a day was ordered on 3/1/16, Guanfacine (for treatment of anxiety disorder) 1 mg 2 times a day was ordered on 3/7/15, aripiprazole (antipsychotic) 2 mg daily was ordered on 3/7/15 and venlafaxine ER (antidepressant) 225 mg daily was ordered on 4/12/17. Review of the Consultant Pharmacist Medication Regimen Reviews dated 2/13/17-2/21/17 and 9/25/17-9/26/17 showed the pharmacist recommended the physician review the medications for a possible gradual dose reduction and document a risk versus benefits rationale if the physician determined the reduction should not be done. Review of the pharmacy consultation report, dated 2/27/17, and the Psychoactive Drug and Behavior Medication Review Form dated 6/20/17 showed the physician response on both was for the medication review to be done by the	F 428		

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F 428	Continued From page 36 psychiatrist. Interview with the DON on 10/4/17 at 11:10 AM revealed a psychiatrist was not available at the time the pharmacist made his initial recommendation. She further stated the review for the gradual dose reduction had not been done because they did not have a psychiatrist until September 2017. 9. Interview on 10/4/17 at 12 PM with the consultant pharmacy revealed he had identified the concern with the physician's not acting upon the recommendations and had recently presented it to the facility's quality assurance committee.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		10/27/17

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	535013	A. BUILDING _____ B. WING _____	10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 431	Continued From page 37 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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. (h) Storage of Drugs and Biologicals. (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. (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: Based on observation, staff interview, and review of facility policy, the facility failed to ensure medications for resident use were not past their expiration date in 6 of 6 medication carts. The findings were: 1. Observation of medication cart A located on first floor on 10/3/17 at 10:20 AM revealed clortrimazole TRO 10 milligram (mg) did not have	F 431	F431 1. Clortimazole TRO 10 mg, located in the first floor medication cart A was removed from cart on 10/04/2017. Klor-Con 20 mg located in the first floor medication cart B was removed from cart on 10/04/2017. Zofran 4 mg located in the medication cart on the second floor was removed from	

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F 431	Continued From page 38 an expiration date on the label. Interview with RN # 1 revealed the medications in the cart were for resident use. 2. Observation of medication cart B located on the first floor on 10/3/17 at 10:33 AM revealed Klor-Con 20 milliequivalent (meq) did not have an expiration date on the label. Interview with LPN # 3 revealed the medications in the cart were for resident use. 3. Observation of the medication cart located on the second floor on 10/3/17 at 11:35 AM revealed Zofran 4 mg with an expiration date of 5/26/17 on the label. Interview with RN # 2 revealed the medications in the cart were for resident use. The RN also stated the Zofran came from the home of a resident's who was admitted 8/29/17. The RN further stated the resident had not received that medication since admission. 4. Observation of medication cart B located on the third floor on 10/3/17 at 2:25 PM revealed 4 vials of lidocaine 1% 20 milliliters (ml) did not have the date opened recorded on the label. Interview with LPN # 2 revealed the vials were used for residents. Review of the Vials and Ampules of Injectable Medications policy showed "The date opened and initials of the first person to use the vial are recorded on multidose vials on the vial label....." 5. Observation of medication cart A located on the third floor on 10/3/17 at 3:00 PM revealed Dulcolax suppository had an expiration date of 5/15/17 and oxycodone/acetaminophen 0.5mg/325mg had an expiration date of 7/18/17. Interview with LPN # 1 revealed the medications were for resident use and were past their	F 431	cart on 10/04/2017. Vials of lidocaine located in the third floor medication cart B was removed from cart on 10/04/2017. Dulcolax suppository and oxycodone 0.5mg/ 325 mg located in the medication cart A on the third floor was removed from cart on 10/04/2017. Multi vitamin with iron located in the medication cart on the third floor secured unit was removed from cart on 10/04/2017. 2. The Director of Nursing or designee will complete an audit on or by 10/27/2017 of medication carts to validate medications are labeled with an expiration date, expired medications are removed and open vials are initialed and dated when opened. 3. The Staff Development Coordinator or designee will educate facility nurses on or before 10/27/2017 to validate medications are labeled with an expiration date, expired medications are removed and open vials are initialed and dated when opened. 4. The Director of Nursing or designee will complete a weekly audit for 60 days of medication carts to validate medications are labeled with an expiration date, expired medications are removed and open vials are initialed and dated when opened. The Director of Nursing or designee will report the tracking and trending of the	

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F 431	Continued From page 39 expiration date. 6. Observation of the medication cart located in the secure unit on the third floor on 10/3/17 at 2:40 PM revealed multiple vitamin with iron with an expiration date of 9/17. Interview with LPN # 1 revealed the medications were for resident use.	F 431	audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and manufacturer instructions, the facility failed to ensure the accuracy of finger stick blood sugar levels obtained by staff. The findings were: 1. Observation of the medication cart located on the secure unit on the third floor on 10/3/17 at 2:40 PM revealed a bottle of Assure Blood Glucose Strips had an expiration date of 8/17. 2. Interview with LPN # 1 revealed the glucose strips in the medication cart were for resident use and the bottle was beyond its expiration date. 3. Review of the Assure Prism multi blood glucose test strips manufacturer's instructions (www.arkrayusa.com/, pg.10, retrieved 10/10/17) showed "Do not use Assure Prism multi Blood Glucose Test Strips beyond the expiration date as this may cause inaccurate results."	F 502	F502 1. Expired Glucose strips from the Medication Cart located on the secure unit were removed on 10/04/2017. 2. The Director of Nursing or designee will complete an audit on or by 10/27/2017 of medication carts to validate expired glucose strips are removed. 3. The Staff Development Coordinator or designee will educate facility nurses on or before 10/27/2017 to validate expired glucose strips are removed. 4. The Director of Nursing or designee will complete a weekly audit for 60 days of medication carts to validate expired glucose strips are removed. The Director of Nursing or designee will	10/27/17

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F 502	Continued From page 40	F 502	report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the	F 520		10/27/17

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F 520	Continued From page 41 Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the CMS (Centers for Medicare and Medicaid) 2567 Statement of Deficiencies, and review of the facility's quality assessment and assurance information, the facility failed to ensure the quality assessment and assurance program developed and implemented appropriate interventions to effectively resolve and sustain compliance with previously identified deficient practice. The facility census was 110. The findings were: 1. Review of the of the 9/9/16 CMS 2567 Statement of Deficiencies, and quality assessment and assurance program showed the facility failed to resolve and/or maintain compliance with the following deficient practices: a. Issues with the facility's grievance resolution measures were cited during the 9/9/16 survey. A plan of correction was developed and monitored through the facility's quality assessment and assurance program, but the facility was unable to sustain compliance. Issues related to grievance resolution were again cited during the current survey (F244). b. Issues with failing to maintaining a clean environment were cited during the 9/9/16 survey. A plan of correction was developed and	F 520	F520 1. The Executive Director or designee educated Facility Leadership regarding making a good faith effort to resolving and sustaining compliance with previously identified deficient practice through the Quality Assurance process on 10/04/2017. 2. The Facility Quality Assurance team met on 10/17/2017 to re-evaluate the facilities good faith efforts to resolving and sustaining compliance regarding previously identified deficient practice from the 09/04/2016 survey by tracking and trending data to validate substantial compliance is met. 3. The Executive Director or designee will review monthly with the Quality Assurance team to identify trends regarding previously identified deficient practice from the09/04/2016 survey to validate a good faith effort is made to maintain substantial compliance. 4. The Executive Director or designee will report tracking and trending of the	

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F 520	Continued From page 42 monitored through the facility's quality assessment and assurance program, but the facility was unable to sustain compliance regarding environmental issues. This issue was again cited during the current survey (F253). c. Issues with failing to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being address, specifically failure to complete timely assessments, were cited during the 9/9/16 survey. A plan of correction was developed and monitored through the facility's quality assessment and assurance program, but the facility was unable to sustain compliance. Issues related to this failure were again cited during the current survey (F309). d. Issues with the food service not provided accordance with professional standards for food service safety were cited during the 9/9/16 survey. A plan of correction was developed and monitored through the facility's quality assessment and assurance program, but the facility was unable to sustain compliance. Issues related to food temperatures were cited during the current survey (F371). 2. Interview with the administrator on 10/4/17 at 2 PM revealed the facility had been working to address problems they had identified through the quality assessment and assurance process; and determined one of the reasons they were unable to effectively resolve recurrent problems was possibly due to resident and family perceptions. She further stated the plan was to utilize the quality assessment and assurance process to implement measures that would improve resident and family perceptions.	F 520	audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	