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 _____	10/12/2018

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 which included complaints WY00002502, WY00002518, WY00002531, WY00002631, and WY00002693, was conducted by Healthcare Licensing and Surveys from 10/8/18 through 10/12/18. The following common abbreviations are used throughout this document: ADL- Activities of Daily Living CDM- Certified Dietary Manager CNA- Certified Nurse Aide DON- Director of Nursing HSA- Hospitality Services Aide LPN- Licensed Practical Nurse MDS- Minimum Data Set PPE- Personal Protective Equipment RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		11/3/18

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

Electronically Signed | 11/02/2018

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 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to maintain dignity for 1 of 6 sample residents (#8) with incontinence. The findings were: 1. Review of the significant change MDS assessment dated 7/7/18 showed resident #8 had diagnoses which included neurogenic bladder, dementia, and multiple sclerosis. Further review showed the resident required extensive	F 550	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	

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F 550	Continued From page 2 assistance of one person for transfer, dressing, toilet use, and personal hygiene. Review of the incontinence care plan last revised on 10/4/18 showed "check for incontinence..." Review of the ADL care plan last revised on 10/4/18 showed "nursing to provide assist with bed mobility, transfers, locomotion in w/c, dressing, toilet use, personal hygiene, and bathing." The following concerns were identified: a. Observation on 10/08/18 at 4:21 PM showed resident #8 was assisted off the elevator on the second floor unit and into his/her room by another unidentified resident. Resident #8's pants were visibly soiled from the upper inner thighs down to the bottom of the pant leg. Interview with the resident at that time revealed the wet area was urine and s/he had just returned to the second floor after being downstairs. b. Interview with the DON on 10/11/18 at 3:54 PM revealed the resident traveling through the facility with urine-soaked clothing could be undignified for the resident.	F 550	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 F550 1. Resident #8 interviewed to validate that her toileting needs are met by 10/31/2018. 2. The Director of Nursing or designee observed residents for whom are dependent with toileting needs and have urinary incontinence according to the plan of care to validate that the residents toileting needs are met by 10/16/2018. 3. The Staff Development Coordinator or designee will educate staff by 10/25/2018 on toileting frequency as specified by the care plan for residents whom are dependent with toileting needs. 4. The Director of Nursing or designee will randomly audit 10 residents daily, 5 days per week for 90 days to validate toileting needs are met. 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		11/3/18

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F 561	Continued From page 3 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to promote resident choices with 2 of 4 sample residents (#24, #91). The findings were: 1. Interview with resident #24 on 10/8/18 at 4:42 PM revealed residents go without a bath or shower for "weeks." The resident stated, "We are supposed to have one twice a week. It would be nice to have one twice a week." a. Review of the resident's "2nd floor shower schedule" showed the resident was scheduled for showers on Tuesdays and Fridays.	F 561	F561 1. Resident #24 Expired. Resident #91 received a shower twice per week on 10/18/2018. 2. The Director of Nursing or designee will audit for resident□s shower preference by 10/31/2018. 3. The Staff Development Coordinator or designee educated staff to validate resident shower preferences are honored and scheduled on 10/25/2018. 4. The Director of Nursing or designee will randomly audit shower logs weekly to	

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F 561	Continued From page 4 b. Review of the care plan showed the resident preferred to take his/her showers after breakfast. c. Review on 10/10/18 of the "resident functional performance record" for October 2018 showed the resident did not receive a shower for 9 days between 10/1/18 and 10/9/18. 2. Observation on 10/8/18 at 10:15 AM showed resident #91 had visible facial hair on his/her chin. Interview with CNA #1 at that time revealed the residents were shaved when they get their bath. The following concerns were identified: a. Review on 10/10/18 of the "resident functional performance record" for October 2018 showed the resident did not receive a shower for 9 days between 10/1/18 and 10/9/18. 3. Interview with the DON on 10/12/18 at 10:25 AM confirmed the residents were to receive a shower/bath 2 times a week.	F 561	validate showers are completed timely for 90 days. 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		11/3/18

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F 578	Continued From page 5 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medical record accurately reflected resident advance directive preferences for 2 of 7 sample residents (#2, #16) reviewed for advance directives. The findings were: 1. Review of the "WyoPOLST (Providers Orders for Life Sustaining Treatment)" dated 1/14/17 showed resident #2 elected a "do not attempt resuscitation (DNR) with selective treatment designation." Review of the nurses 24 hour staff	F 578	F578 1. Resident #2 care plan was updated to DNR with Selective Treatment on 10/12/2018. Resident #16 expired. 2. The Social Services Director or designee will audit WYO POLST forms to validate the plan of care accurately reflects the resident advanced directive preference by 10/12/2018. WYO POLST forms that do not accurately reflect the resident advanced directive preference will be corrected by 11/03/2018.	

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F 578	Continued From page 6 report sheet showed the resident had a code status of DNR. Review of the resident care plan dated 9/15/18 showed the code status as "cardiopulmonary resuscitation (CPR) requested." 2. Review of the "WyoPOLST" dated 9/20/18 showed resident #16 elected a "DNR" status with "full treatment". Review of the nurses 24 hour staff report showed only DNR. Review of resident care plan dated 9/23/18 showed the code status was "full code." 3. Interview with CNA #2 on 10/9/18 at 11:12 AM revealed that, regardless of resident code status, she would call for help if a resident was unresponsive and begin CPR. 4. Interview with RN #1 on 10/10/18 at 10:03 AM stated he would go to the resident medical record and check the "POLST" to determine the resident's code status as the nurses 24 hour report sheet did not accurately identify resident code status. 5. Interview with the DON on 10/12/18 at 10:25 AM stated the facility would expect staff to follow the resident's "POLST" election at all times.	F 578	3. The Staff Development Coordinator or designee will educate staff to validate the plan of care accurately reflects the resident advanced directive preference on 10/25/2018. 4. The Social Services Director or designee will randomly audit WYO POLST forms weekly for 30 days to validate the plan of care accurately reflects the resident advanced directive preference. The Director of Social Services 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 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §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 physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms,	F 604		11/3/18

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F 604	Continued From page 7 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, 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 physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure a physical restraint had been assessed and was the least restrictive for 1 of 1 sample resident (#72) who was restrained. The findings were: 1. Review of the quarterly MDS assessment dated 8/30/18 showed resident #72 had diagnoses which included dementia, anxiety disorder, difficulty in walking, and muscle weakness. Further review showed the resident had short term and long term memory problems, no coded behaviors, and required extensive assistance of two or more people for toilet use, transfers, walking in room and corridor,	F 604	F604 1. Resident #72 restraint assessment completed by 10/31/2018. 2. The Director of Nursing or designee will complete an audit of residents whom have a history of aggressive behaviors to validate that a physical restraint assessment is completed on 10/30/2018. 3. The Staff Development Coordinator will educate staff to validate that residents are free from physical restraints on 10/25/2018. 4. The Director of Nursing or designee will randomly observe 3 residents weekly for 90 days to validate residents are free	

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F 604	Continued From page 8 locomotion, and dressing. Review of the behavior care plan last revised on 9/11/18 showed the resident had "potential for unprovoked aggressive behaviors toward others" and interventions included assessment for basic needs, eliminate causes of distress, handling situations "as calmly as possible," unrushed and constant routine, and diversional activities geared toward the resident's interest. The following concerns were identified: a. Observation on 10/8/18 at 11:11 AM showed resident #72 attempted to stand from his/her wheelchair and HSA #1 stood behind the resident. At that time, the HSA placed her arms around the resident, placed her hands on the resident's forearms, and applied pressure while stating "[resident's name] you can't stand up" in an attempt to get the resident to return to sitting in the wheelchair. The resident stated "stop pushing me." The HSA remained behind the resident, and when the resident attempted to stand again, she placed her hands on the resident's shoulders and applied pressure to get the resident to sit in his/her chair. The HSA stated, "You have to sit down [resident's name]." The resident said, "Stop it." The HSA remained behind the resident and when the resident attempted to stand a third time, the HSA placed her hands on the resident's hips and applied pressure. The resident said, "Stop it, leave me alone. Stop pushing me." The HSA responded to the resident "You have to sit down [resident's name]." b. Interview with HSA #2 on 10/11/18 at 3:18 PM revealed when the resident tried to get up it was "best to talk to [him/her] and maybe rub [his/her] back." The HSA revealed if staff tried to apply pressure to the resident's arms or shoulders it agitated him/her more and resulted in increased behaviors. Further, she confirmed applying pressure to the resident's extremities in	F 604	from physical restraints. 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 604	Continued From page 9 an attempt to get him/her to sit down prevented the resident from moving independently. c. Interview with the DON and unit manager #1 on 10/11/18 at 3:38 PM revealed staff should allow the resident to stand and ensure s/he was safe. Further, it was revealed the resident "became agitated" when people were "hovering over [him/her]" or applying pressure to try and get him/her to sit down.	F 604		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(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 body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(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. This REQUIREMENT is not met as evidenced by: Based on review of employee files and staff interview, the facility failed to ensure employed	F 606	F606 1. CNA #4 was entered into the nurse	11/3/18

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F 606	Continued From page 10 CNAs were entered into the nurse aide registry for 1 of 2 CNAs reviewed (CNA #4). The findings were: Review of the employee file showed CNA #4 had a date of hire of 9/12/18. Further review showed no evidence the CNA was entered into the state nurse aide registry. Interview on 10/12/18 at 9:10 AM with administrative assistant #1 confirmed the facility did not enter the CNA into the nurse aide registry. She further stated that action was usually completed on orientation.	F 606	aide registry by 10/19/2018. 2. The Business Office Manager or designee will complete an audit on 10/12/2018 of employee files to validate employed CNAs are entered into the nurse aide registry. Employed CNAs found that are not entered into the nurse aide registry will be corrected by 11/03/2018. 3. The Executive Director or designee will educate staff on 10/25/2018 to validate employed CNAs are entered into the nurse aide registry. 4. The Business Office Manager or designee will randomly audit newly hired CNA files weekly to validate employed CNAs are entered into the nurse aide registry. The Business Office 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.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		11/3/18

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F 623	Continued From page 11 (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F 623		

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	535013	A. BUILDING _____ B. WING _____	10/12/2018

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F 623	Continued From page 12 including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the	F 623		

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F 623	Continued From page 13 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued to 2 of 7 sample residents (#36, #37) with hospital transfers. The findings were: 1. Review of the medical record for resident #36 showed the resident was transferred to the hospital on 6/7/18 and returned on 6/18/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident representative. 2. Review of the medical record for resident #37 showed the resident was transferred to the hospital on 4/15/18 and returned on 4/17/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or resident representative. 3. Interview with the admission/discharge coordinator on 10/10/18 at 10:13 AM confirmed the facility had identified a failure to issue written notices of transfer, and had started education of staff in August.	F 623	F623 1. Resident #36 was transferred back to the facility on 06/18/2018. Resident # 37 was transferred back to the facility on 04/17/2018. Staff have been educated regarding timely transfer notification on 10/25/2018. 2. The Executive Director or designee will educate the Admissions Director on 10/12/2018 to validate that the transfer notice is given according to the regulation. The Admissions Director or designee completed an audit by 10/19/2018 to validate that the transfer notice is given according to the regulation, transfer notices not found in compliance between 10/17/2018- 10/19/2018 were corrected by 10/19/2018. 3. The Staff Development Coordinator or designee will educate staff on 10/25/2018 to validate that the transfer notice has been given according to regulation. 4. The Admissions Director or designee will complete a weekly audit for 60 days to validate timely transfer notice has been given according to regulation. The Admissions 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	

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F 623	Continued From page 14	F 623	committee.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a notice of bed-hold policy was issued to 2 of 7 sample residents (#36, #37) who transferred to the	F 625	F625 1. Resident #36 was transferred to the hospital on 06/7/2018 and back to the facility on 06/18/2018. Resident # 37 was	11/3/18

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F 625	Continued From page 15 hospital. The findings were: 1. Review of the medical record for resident #36 showed the resident was transferred to the hospital on 6/7/18 and returned on 6/18/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident representative. 2. Review of the medical record for resident #37 showed the resident was transferred to the hospital on 4/15/18 and returned on 4/17/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or resident representative. 3. Interview with the admission/discharge coordinator on 10/10/18 at 10:13 AM confirmed the facility had failed to issue written notices to the resident or resident representative concerning the bed-hold policy for hospital transfers.	F 625	transferred to the hospital on 04/15/2018 and back to the facility on 04/17/2018. The Staff Development Coordinator educated staff to validate that the bed hold notification is given per the regulation on 10/25/2018. 2. The Executive Director or designee educated the Admissions Director on 10/12/2018 to validate that the bed hold notice is given according to the regulation. The Admissions Director or designee completed an audit by 10/19/2018 to validate that the bed hold notice is given according to the regulation, bed hold notices not found in compliance between 10/17/2018- 10/19/2018 were corrected by 10/19/2018. 3. The Staff Development Coordinator or designee will educate staff on before 10/25/2018 to validate timely bed hold notification. 4. The Admissions Director or designee will complete a weekly audit for 60 days to validate that the bed hold notification has been given timely. The Admissions 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.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		11/3/18

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F 645	Continued From page 16 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under	F 645		

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F 645	Continued From page 17 paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, and review of Wyoming Medicaid PASRR guidelines, the facility failed to ensure residents with categorical determinations had a PASRR Level II completed within the identified time frames for 1 of 3 sample residents (#81) reviewed. The findings were: 1. Review of the significant change MDS assessment dated 9/12/18 showed resident #81 was admitted to the facility on 5/21/18, had physical behaviors 4 to 6 days and verbal behaviors 1 to 3 days during the look back period, and diagnoses which included anxiety disorder	F 645	F645 1. Resident #81 received a timely PASRR II, validated by Wyoming Medicaid office on 10/24/2018. 2. In unique situations when a PASRR I and PASRR II is process prior to admission and the residents□ status changes which a PASRR I notes a categorical 6, the Admissions Director or designee will request an additional PASRR II. The Admissions Director or designee completed an audit on 10/31/2018 of Categorical 6 PASRR I that fall into this unique situation to validate	

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F 645	Continued From page 18 and depression. The following concerns were identified: a. Review of a PASRR Level I dated 5/21/18 showed the resident had a psychiatric diagnosis and received a categorical 6 determination. Further review showed the categorical 6 determination qualified the resident for "convalescent care after acute hospital stay, not to exceed 120 days" and the facility was to "attach current LT101, current history and physical, and comprehensive drug history. An individual Level II determination will be required on 121st day, please plan accordingly." b. Review of a PASRR Level II determination completed on 5/23/18 showed the determination was requested on 5/18/18, prior to the resident's hospitalization. The determination was completed 2 days following the resident's admission to the facility, however there was no evidence a PASRR Level II was requested after the resident had been at the facility for 30 days. c. Review of the "Wyoming MEDICAID PASRR Update" dated 8/2017 showed "...Categorical 6- A medical condition following a discharge from an acute care hospital, for which convalescent care is expected to require less than 120 days in a NF [nursing facility]...If the individual will continue to require NF placement, past the day limit stated above, he/she MUST have a full Level II PASRR evaluation completed BEFORE the end of the exempted period. (A new PASRR Level I needs to be repeated in the portal and PASRR II packet faxed to Optum). The earliest a provider can submit a request for an expiring Categorical Determination PASRR II is 30 days after admission..." d. Interview with the admissions coordinator on 10/11/18 at 4:05 PM revealed the resident was going to be admitted from another skilled nursing	F 645	timely submission of a PASRR II, PASRRs found in this unique situation were corrected by 11/03/2018. 3. The Executive Director or designee will educate the Admissions Director or designee on or before 10/20/2018 to validate timely submission of a PASRR II. 4. The Admissions Director or designee will complete a monthly audit for 60 days of Categorical 6 PASRR I that fall into this unique situation to validate timely submission of a PASRR II. The Admissions 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 645	Continued From page 19 facility which resulted in the facility initiating the PASRR II on 5/18/18; however, the resident was hospitalized on 5/19/18 and required the completion of a PASRR Level I which resulted in the categorical 6 determination.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		11/3/18

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F 656	Continued From page 20 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the comprehensive care plan addressed all required areas for 1 of 30 sample residents (#30) who required a care plan. The findings were: Review of the 7/27/18 quarterly MDS assessment showed resident #30 was admitted to the facility on 1/21/14 with diagnoses which included non-Alzheimer's dementia, depression, anxiety disorder, seizure disorder, and diabetes mellitus type II. Review of physician orders showed the resident was admitted to hospice on 9/29/18. Review of the care plan showed the facility failed to address the resident's hospice services on the plan, and no delineation between facility services and hospice services was addressed. Interview with unit manager #1 on 10/11/18 at 12:02 PM confirmed the facility failed to address hospice services on resident #30's care plan.	F 656	F656 1. Resident #30 has a hospice plan of care on 10/16/2018. 2. No other residents are on Hospice care. 3. The Director of Nursing or designee will educate staff to validate that a Hospice plan of care is in the residents care plan on 10/25/2018. 4. The Director of Nursing or designee will monitor monthly for 90 days for Residents on Hospice to validate that the care plan addresses Hospice level 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.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		11/3/18

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F 689	Continued From page 21 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, family and staff interview, the facility failed to ensure the care plan was followed concerning safety interventions for 1 of 4 sample residents (#30) identified with fall issues. The findings were: Observation on 10/8/18 at 4:46 PM showed resident #30 was in bed in a low position with a fall mat by the bed. Interview with a family member of the resident at that time showed the resident had fallen in the past, and the fall mat was a safety intervention the facility had added to lessen the risk of injury if the resident fell out of bed. Review of the care plan showed a 1/1/18 plan that addressed the resident's risk of falls. The plan had been revised several times, and included the intervention "Lip mattress on floor by bedside to set parameters when in bed." The following concerns were identified: a. Observation on 10/11/18 from 2:09 PM through 5:51 PM showed the resident was asleep in bed with the bed in a low position. However, the required lip mattress was not on the floor. A fall mat was behind the bed against the wall and not on the floor by the bedside. There were no visitors or staff with the resident during the observation period. b. Interview with unit manager #1 on 10/11/18 at 5:51 PM confirmed the resident's lip mattress (or fall mat) should have been on the floor beside the bed for safety as per the care plan.	F 689	F689 1. Resident #30 care plan was updated to include fall mat by bed on 10/16/2018. 2. The Director of Nursing Services will audit residents with fall mats to validate that the fall mat is care planed on 10/30/2018. Fall mats found to not be care planned were care planned for residents who needed them by 11/03/2018. 3. The Staff Development Coordinator or designee will educate facility staff to validate that fall mats are care planned and place on the floor when the resident is in bed on 10/25/2018. 4. The Director of Nursing or designee will randomly audit three (3) residents per week for 90 days to validate that the fall mat is care planned and placed on the floor when the resident is in bed. 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 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 690	F690	11/3/18

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GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 690	Continued From page 23 interview, and medical record review, the facility failed to ensure residents received appropriate services and treatment for 5 of 7 sample residents (#8, #46, #72, #81, #322) who were incontinent. The findings were: 1. Review of the significant change MDS assessment dated 7/7/18 showed resident #8 had diagnoses which included neurogenic bladder, dementia, and multiple sclerosis. Further review showed the resident required extensive assistance of one person for transfer, dressing, toilet use, and personal hygiene. Review of the incontinence care plan last revised on 10/4/18 showed "check for incontinence..." Review of the ADL care plan last revised on 10/4/18 showed "nursing to provide assist with bed mobility, transfers, locomotion in w/c, dressing, toilet use, personal hygiene, and bathing. The following concerns were identified: a. Observation on 10/08/18 at 4:21 PM showed resident #8 was assisted off the elevator on the second floor unit and into his/her room by another unidentified resident. Resident #8's pants were visibly soiled between his/her upper inner thighs down to the bottom of his/her pant leg. Interview with the resident at that time revealed the wet area was urine and s/he had just returned to the second floor after being downstairs. b. Observation on 10/11/18 beginning at 8:41 AM showed the resident was sitting at a table in the second floor unit dining room. The resident left the unit and rode the elevator to the first floor at 10:29 AM. The resident returned to the dining room table on the second floor unit at 10:56 AM. Interview with CNA #3 on 10/11/18 at 1:09 PM revealed the resident had not been offered or assisted to use the restroom since s/he got up for the day. Further the CNA revealed she was going	F 690	1. Resident #8, #46, #72, #81, and #322 received incontinence care on or before 10/31/2018 daily upon rising, before and/or after meals, at bedtime and as needed to include frequent rounding at night as needed. 2. The Director of Nursing or designee observed residents for whom are dependent with toileting needs and have urinary incontinence according to the plan of care to validate that the residents toileting needs are met by 10/16/2018. Residents identified in this audit were/ are toileted daily upon rising, before and/or after meals, at bedtime and as needed to include frequent rounding at night as needed. 3. The Staff Development Coordinator or designee educated staff on 10/25/2018 on toileting frequency as specified by the care plan for residents whom are dependent with toileting needs. 4. The Director of Nursing or designee will randomly audit 10 residents daily, 5 days per week for 90 days to validate toileting needs are met. 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.	

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F 690	Continued From page 24 to ask the resident at that time. Continued observation showed the resident remained at the dining table until 1:11 PM, 4 hours and 30 minutes after the observation began. Interview with CNA #3 at 1:13 PM confirmed the resident's brief was wet and had to be changed. 2. Review of the significant change MDS assessment completed on 8/23/18 showed resident #46 had diagnosis which included dementia, abnormalities of gait and mobility, and weakness. Further the resident required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. Review of the "bladder incontinence" care plan last revised on 8/10/18 showed "...Brief Use: [resident's name] uses disposable briefs. Change after each incontinent episode and prn [as needed]..." Review of the ADL care plan last revised on 8/24/18 showed "...Toilet USE: [resident's name] requires assistance by staff for toileting. Review of the "high risk for falls" care plan last revised on 10/9/18 showed "...Toilet before and after meals and PRN. Provide assistance with toileting needs..." The following concerns were identified: a. Observation beginning on 10/10/18 at 8:58 AM showed the resident was in the common area during exercise activity. The resident was sleeping in his/her wheelchair. At 9:25 AM CNA #7, CNA #8 and CNA #9 assisted the resident into his/her room and into bed without assisting him/her to the bathroom or performing incontinence care. The resident remained in bed until 12:21 PM. Observation at that time showed unit manager #1, LPN #2, and CNA #9 assisted the resident out of bed and did not offer toileting or perform incontinence care. The resident was assisted to a dining table and LPN #2 stated "We	F 690		

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F 690	Continued From page 25 will take you to the bathroom in a little bit" when the resident attempted to leave the table. At 12:26 PM the resident left the table and went to his/her room to use the bathroom. At that time CNA #9 assisted the resident onto the toilet (3 hours and 28 minutes later). b. Interview with CNA #9 on 10/10/18 at 12:29 PM revealed the resident's brief was wet when s/he was assisted to the bathroom. 3. Review of the quarterly MDS assessment dated 8/30/18 showed resident #72 had diagnoses which included dementia, anxiety disorder, difficulty in walking, and muscle weakness. Further review showed the resident had short term and long term memory problems, no coded behaviors, and required extensive assistance of two or more people for toilet use, transfers, walking in room and corridor, locomotion, and dressing. Review of the "Bowel Incontinence" care plan last revised 5/21/18 showed interventions that included "Observe for pattern of incontinence and initiate toileting schedule if indicated. Review of the "Bladder Incontinence" care plan last revised on 5/21/18 showed "[resident's name] uses disposable briefs. Clean peri-area with each incontinence episode." The following concerns were identified: a. Observation beginning on 10/10/18 at 9:06 AM showed the resident was in bed sleeping. At 10 AM CNA #7 assisted the resident out of bed and assisted him/her to a dining table without offering to use the bathroom or performing incontinence care. The resident remained at the dining table until 1:09 PM when CNA #9, CNA #7, and LPN #2 assisted the resident to bathroom (4 hours and 3 minutes later). b. Interview with CNA #9 on 10/10/18 at 1:15 PM revealed the resident's brief was wet with	F 690		

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F 690	Continued From page 26 urine and further it was confirmed the resident was not toileted or provided incontinence care when s/he was assisted out of bed. 4. Review of the significant change MDS assessment dated 9/23/18 showed resident #81 had diagnoses which included osteoporosis, hip fracture, cerebrovascular accident, and dementia. Further review showed the resident required extensive assistance of two or more people for bed mobility, transfers, dressing, and toilet use. The resident required extensive assistance of one person for personal hygiene. Review of the "ADL" care plan last revised on 6/3/18 showed "...Toilet USE: [resident's name] requires extensive assistance for transfers..." The following concerns were identified: a. Observation beginning on 10/10/18 at 8:57 AM showed the resident was in the common area participating in exercises. At 9:40 AM CNA #7 assisted the resident to his/her room to perform hair care and did not offer to take the resident to the bathroom or perform incontinence care. The CNA assisted the resident to return to a dining table in the common area. The resident remained in the common area until s/he asked to use the bathroom at 12:36 PM. CNA #7 assisted the resident to the bathroom at that time (3 hours and 39 minutes later). b. Interview with CNA #7 on 10/10/18 at 12:41 PM revealed the residents brief was soiled. 5. Review of the "48-Hour Baseline Plan of Care Form, " dated 10/4/18, showed resident #322 had diagnoses that included chronic obstructive pulmonary disease, diabetes mellitus, anxiety, and depression. Further review showed the resident required 2-person extensive assist with toileting, was incontinent, and utilized	F 690		

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F 690	Continued From page 27 incontinence products. Review of a "Bladder Evaluation" form, dated 10/4/18, showed the resident had functional incontinence related to physical or cognitive limitations and was dependent on caregivers for toileting. The following concerns were identified: a. Interview with the resident on 10/08/18 at 5:33 PM revealed concerns with receiving the assistance s/he needed to toilet. The resident stated s/he had "wet the bed" through his/her incontinence products while waiting for assistance. Additionally, the resident stated diuretic medication made him/her urinate large amounts. b. Interview on 10/10/18 at 2:50 PM with CNA #5 revealed the resident was usually continent of bladder, "unless we don't get to [him/her] in time." c. Interview on 10/10/18 at 6:22 PM with CNA #6 revealed the resident was normally continent, adding the resident "will tell you when [s/he] has to go, you just have to help [him/her]." d. Review of the resident's bladder function record from 10/3/18 through 10/11/18 showed the resident was continent of bladder 38 times and was incontinent of bladder 19 times. e. Interview on 10/11/18 at 3:54 PM with the DON confirmed the resident required assistance for toileting. She further revealed the resident was usually continent and was able to ask for assistance. 6. Interview with unit manager #1 and DON on 10/11/18 at 3:35 PM revealed the facility expectation was for residents to be taken to the bathroom upon rising, before and after meals, and as needed and the residents should not go longer than 3 hours without toileting.	F 690		
F 755	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		11/3/18

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F 755 SS=D	Continued From page 28 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review the facility failed to ensure medications were not expired in 1 of 6 medication storage areas (2nd floor "A" medication cart). The	F 755	F755 1. Expired medications from Cart A were discarded immediately upon finding during the survey finding.	

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F 755	Continued From page 29 findings were: 1. Observation of the 2nd floor "A" medication cart on 10/11/18 at 4:09 PM showed the following concerns: a. One multiple-dose bubble pack of hydrocodone/acetaminophen (Narcotic pain medication) 5/325 milligram tablets which expired on 5/23/18. b. One multiple-dose bubble pack of tramadol HCL (narcotic pain medication) 50 mg tablets which expired 5/5/18. 2. Interview with LPN #1 on 10/11/18 at 4:18 PM revealed the medications would have been administered to the residents even though the medications were expired. 3. Review of the "Medication storage in the facility" policy and procedure included ...M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures ..."	F 755	2. The Director of Nursing or designee completed an audit on 10/16/2018 of medication carts/ storage to validate that expired medications are discarded. 3. The Staff Development Coordinator or designee educated facility nurses on 10/25/2018 regarding regular checks of medication carts/ storage to validate that expired medications are discarded. 4. The Director of Nursing or designee will complete a weekly audit for 60 days of medication carts/ storage to validate that expired medications are discarded. 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 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §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	F 758		11/3/18

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F 758	Continued From page 30 Based on a comprehensive assessment of a resident, the facility must ensure 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, staff interview,	F 758	F758	

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F 758	Continued From page 31 and policy and procedure review, the facility failed to ensure appropriate medication use for 2 of 5 sample residents (#62, #81) reviewed for psychotropic medications. The findings were: 1. Review of the significant change MDS assessment date 8/4/18 showed resident #62 had diagnoses which included Alzheimer's disease, dementia, anxiety disorder, and depression. Further review showed the resident rejected care and wandered 1 to 3 days during the look back period. Review of the "depression and anxiety" care plan last revised on 5/21/18 showed interventions included "Administer medications as ordered, monitor/document for side effects and effectiveness...Monitor/document/report PRN [as needed] any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness, impaired judgement or safety awareness. Monitor/document/report PRN any s/sx [signs or symptoms] of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, [sic] negative statements, repetitive anxious or health-related complaints, tearfulness. Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons..." Review of the medication administration record (MAR) for October 2018 showed the resident was ordered sertraline hydrochloride (anti-depressant) 100 mg (milligrams) by mouth in the morning for depressive symptoms, haloperidol (antipsychotic)	F 758	1. Behavior monitoring flow sheets for Resident # 62 and #81 were updated to include specific targeted behaviors identified from the care plan by 11/02/2018. 2. The Social Services Director or designee completed an audit by 11/02/2018 of behavior monitoring flow sheets to validate that they include specific targeted behaviors identified from the care plan. Behavior monitoring flow sheets that did not include specific targeted behaviors were updated by 11/03/2018. 3. The Staff Development Coordinator or designee educated staff on 10/25/2018 to validate that the behavior monitoring flow sheets include specific targeted behaviors identified from the care plan. 4. The Social Services Director or designee will complete a weekly audit for 90 days of new admissions, psychotropic medication changes and residents being reviewed for quarterly review to validate that the behavior monitoring flow sheets include specific targeted behaviors identified from the care plan. The Social 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 758	Continued From page 32 0.5 mg by mouth every morning and at bed time for behaviors and psychological symptoms of dementia, and Xanax (anti-anxiety) 0.5 mg by mouth every morning and at bedtime for increased agitation/aggression. The following concerns were identified: a. Review of a "Behavior Monitoring Flowsheet" dated 10/2018 showed the monitored behavior was "aggression directed at others," the identified trigger was "Dx [diagnosis] of dementia," and interventions included "1. Redirect as able 2. Offer [him/her] something to hold onto 3. Involve family 4. R/O [rule out] unmet needs." Further review showed the monitoring did not include specific target behaviors identified for the use of individual medications and did not include specific target behaviors identified on the resident's care plan. 2. Review of the significant change MDS assessment dated 9/12/18 showed resident #81 had diagnoses which included dementia, anxiety disorder, and depression. Further review showed the resident had physical behavioral symptoms directed at other on 4 to 6 days and verbal behavioral symptoms directed towards others on 1 to 3 days during the look back period. Review of the "depression" care plan last revised on 6/3/18 showed interventions which included "...Monitor/document/report PRN any s/sx of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, [sic] negative statements, repetitive anxious or health-related complaints, tearfulness..." Review of the "mood problem" care plan last revised on 9/17/18 showed "...Anticipate [resident's name] impulsive behavior and attempt to keep others at least an arm length's away...Monitor for signs of increased anxiety, change in mood, aggression,.	F 758		

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F 758	Continued From page 33 Keep [him/her] away from other residents during those times..."[resident's name] can be intrusive and wander into others personal space and room...[resident's name] can be resistive to care-hit, kick, and throw items. Offer reassurance, take to quiet area..." Review of the MAR for October 2018 showed the resident received duloxetine hydrochloride (antidepressant) 60 mg capsule by mouth in the morning for major depressive disorder, Ativan (anti-anxiety) Benadryl (antihistamine) Haldol (antipsychotic) Reglan (anti-emetic) [ABHR] gel 1 ml (milliliter) transdermally on the wrists every morning and at bedtime for pain/aggression, and Risperdal (antipsychotic) 0.25 mg by mouth at bedtime. The following concerns were identified: a. Review of a "Behavior Monitoring Flowsheet" dated 10/2018 showed the monitored behavior was "aggression directed at others," the identified trigger was "1. Dx of dementia 2. DX of depression 3. Over stimulation," and interventions included "1. Redirect as able 2. Involve family 3. 1:1 conversation 4. R/O [rule out] unmet needs." Further review showed the monitoring did not include specific target behaviors identified for the use of individual medications and did not include specific target behaviors identified on the resident's care plan. 3. Interview with the DON on 10/12/18 at 9:15 AM confirmed the behavior monitoring did not identify specific behaviors for individual medications, the behaviors on the care plan did not match the behaviors the facility was monitoring for medication use, and the rational for effectiveness of medications could not be determined from the behavior monitoring. 4. Review of the policy titled "Behavior	F 758		

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(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 758	Continued From page 34 Management" last revised 10/2017 showed "...5. If a resident exhibits a new behavior symptom, staff implements the Behavior Monitor Flowsheet and notifies Social Services Director (SSD) and the IDT via the 24-hour Report. 6. The Behavior Monitor Flowsheet (number of behaviors, trigger, intervention, and outcome) is completed as the indicated behaviors are exhibited. 7. The IDT reviews the resident's record and Behavior Monitoring Flowsheet (as applicable) to evaluate whether the current plan is effective. If the plan is effective, the IDT makes a note in the medical record. If further evaluation is is needed, modification, including adding changes to care plan and Behavior Monitoring Flowsheet using non-medication interventions, are implemented..."	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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.	F 812		11/3/18

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	535013	A. BUILDING _____ B. WING _____	10/12/2018

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GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 812	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, review of the "Ice Machine PM Task Sheet", and staff interview, the facility failed to ensure food was stored/prepared under sanitary conditions in 1 of 1 kitchens. In addition, the facility failed to ensure 1 of 2 ice machines were sanitary. The findings were: 1. Observation on 10/10/18 at 10:12 AM in the kitchen showed 14 of 34 available serving trays were damaged with the metal underneath showing through and starting to rust. Interview with the CDM on 10/10/18 confirmed the food trays were damaged. 2. Observation on 10/10/18 at 11:39 AM showed two ice machines in the beverage area. The ice machine on the left had paint chipped on the left of the door. Further, there were whitish mineral deposit stains on the bottom right side of the door, and above the door area on the right side of the machine that went the length of the machine. Inside the ice machine where ice collected for use there was a thumb-sized deposit of a dark substance that appeared hardened on the right wall. 3. Interview with the CDM on 10/11/18 at 5:45 PM confirmed the dirty ice machine. He stated the maintenance department cleaned the ice machines, and the kitchen staff did not have a schedule to observe the ice machines. 5. Interview with the maintenance director on 10/12/18 at 8:44 AM revealed the maintenance department emptied and cleaned both ice machines inside and out once a month. He then provided a copy of the 2018 "Ice Machine PM	F 812	F812 1. The Dietary Manager or designee made a good faith effort to removing damaged serving trays and replaced them with newly purchased trays on 10/26/2018. The left side of the Ice machine had a paint chip that was repaired and the ice machine was cleaned of mineral deposits on 10/31/2018. 2. The Dietary Manager or designee audited kitchen appliances to validate the equipment is free of rust and mineral deposits on 10/31/2018. 3. The Dietary Manager or designee will educate dietary staff on 10/26/2018 to validate that the kitchen equipment is free of rust and mineral deposits. 4. The Dietary Manager or designee will randomly audit kitchen appliances weekly for 60 days to validate the equipment is free of rust and mineral deposits. The Dietary 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.	

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F 812	Continued From page 36 Task Sheet" that the subsequent review showed the last date the ice machines were cleaned as 9/24/18. According to Food Code 2017, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.	F 812		
F 880 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. §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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		11/3/18

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F 880	Continued From page 37 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 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.	F 880		

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F 880	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure appropriate infection control practices were followed during 2 random observations of wound care which affected 2 sample residents (#70, #88). The findings were: 1. Review of an "SBAR [Situation, Background, Assessment, Request] Communication Form" showed resident #88 began showing signs and symptoms of abdominal pain and diarrhea on 9/29/18. Review of the "Contact Isolation Care Plan" showed it was initiated on 9/30/18. The plan showed the resident required contact isolation precautions related to a diagnosis of "Positive C-Diff [clostridium difficile]." Approaches included "Inservice direct staff on contact isolation techniques." The following concerns were identified: a. Observation of the wound care nurse on 10/11/18 at 9:09 AM showed the nurse finished wound care for the resident and exited the resident's room without performing hand hygiene, and while wearing a gown and mask. Further observation showed the wound nurse walked to the second floor dining area and removed the gown, using an ungloved hand, by grabbing the gown on the exterior surface and pulling the gown away from her body. The wound nurse discarded the PPE in a trash can on the medication cart, walked to a cart outside the isolation room, and handled items in and on the cart without performing hand hygiene. b. Interview with the staff development coordinator on 10/11/18 at 4:56 PM revealed donning of PPE should be performed prior to resident care and doffing PPE should be	F 880	F880 1. The Wound Care Nurse received sterile technique for wound care, proper hand washing technique and appropriate donning on and doffing off PPE education on 10/26/2018. There are no ill effects to resident #70 and #88 involved during this observation. 2. The Staff Development Coordinator or designee performed competency review with nursing staff to validate sterile technique for wound care, proper hand washing technique and appropriate donning on and doffing off PPE on 10/31/2018. 3. The Staff Development Coordinator or designee provided education to staff to validate proper hand washing technique and appropriate donning on and doffing off PPE on 10/25/2018. 4. The Staff Development Coordinator or designee will randomly audit 5 staff members weekly for 90 days to validate either a sterile technique for wound care, proper hand washing technique or appropriate donning on and doffing off PPE. The Staff Development 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 880	Continued From page 39 completed prior to leaving the resident's room. Further she revealed PPE used during treatment of a resident on isolation precautions should not be worn in a common area or dining room, PPE should be discarded in appropriate receptacles, and employees should wash his/her hands with soap and water prior to leaving the room. c. Review of the policy titled "Personal Protective Equipment (PPE) Work Practices" dated 09/2017 showed "...8. All PPE is removed prior to leaving the work area. a. Contaminated garments are removed immediately or as soon as feasible. b. Removed PPE are placed in a designated or [sic]container for storage, washing, decontamination, or disposal...Contact Precautions:...c. Gloves and Handwashing...iii. Remove gloves before leaving the room and perform hand hygiene...d. Gown i. wear a disposable gown upon entering Contact Precautions room or cubicle. ii. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces..." 2. Observation of the wound care nurse on 10//11/18 at 9:21 AM showed the nurse gathered supplies needed for wound care for resident #70, then moved the trash can close to the bed. The nurse donned gloves and removed the dressing on the resident's heel using both hands. Hand hygiene was not performed prior to donning gloves. The nurse gathered the dressing in her left hand and discarded it. She removed her left glove and replaced it. The dressing change was completed and the nurse removed both gloves. The nurse left the room without performing hand hygiene at 9:36 AM. The nurse returned to the room at 9:39 AM and donned gloves without performing hand hygiene. She performed wound	F 880		

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F 880	Continued From page 40 care to the resident's buttock area, removed her gloves, and washed her hands. 3. Interview with the DON on 10/12/18 at 10:17 AM revealed it was the facilities expectation for staff to perform hand hygiene upon entry to a room and exit of a room. In addition hand hygiene should be performed after removal of dirty gloves and prior to applying new dressing. 4. Review of the "Handwashing/Hand Hygiene" policy and procedure included the following: ...6. ...Wash hands with soap and water for the following situations: ... b. After contact with a resident with known or suspected with infectious diarrhea including, but not limited to infections caused by norovisus, salmonella, shigella, and C. difficile... ...7. g. Before handling clean or soiled dressings, gauze pads, etc.; ...k. After handling used dressings, contaminated equipment, etc. ... m. After removing gloves. n. Before and after entering isolation precaution settings.	F 880		