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 _____	C 04/11/2019

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GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 4/7/19 through 4/11/19. Also reviewed in the course of the survey were complaint intakes WY00002730, WY00002753,WY00002765, WY00002800, WY00002804, WY00002806, WY00002807, WY00002808, WY00002809, and WY00002813. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing HSA: Hospitality Service Aide LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set mg: Milligrams PRN: Pro re nata (as needed) RN: Registered Nurse TAR: Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=E	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.	F 550		5/15/19

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

Electronically Signed | 05/03/2019

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F 550	Continued From page 1 §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 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, staff interview, and medical record review, the facility failed to ensure residents were treated in a dignified manner. This failure affected 4 of 37 sample residents (#24, #62, #112, #220). The findings were:	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	

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F 550	Continued From page 2 1. Review of the 2/1/19 annual MDS assessment showed resident #24 had moderate cognitive impairment; required supervision with ambulation; and required extensive assistance with toileting, dressing, and personal hygiene. Review of the care plan, revised 12/27/18, showed the resident was at risk for ADL self-care performance deficit related to diagnoses of dementia, change in cognitive status, vision problems, and incontinence. Further review showed care plan interventions included directions for staff to assist the resident with choosing simple comfortable clothing that enhanced his/her ability to dress self and provide supervised assistance with dressing. The following concerns were identified: a. Observation on 4/7/19 from 4:45 PM to 9:30 PM showed the resident wore his/her shirt inside out. Continuous observation showed the shirt seams were visible and the buttons were interiorly positioned against his/her chest. Further observation showed the resident ambulated independently throughout the halls and dining area. b. Observation on 4/8/19 from 8:50 AM to 2:30 PM showed the resident wore the same shirt inside out. c. Observation on 4/9/19 at 10 AM showed the resident continued to wear the same shirt inside out. At that time the DON was observed walking with the resident to his/her room to change the shirt. Continued observation showed the resident was compliant and allowed the DON to assist him/her without resistance. 2. Observation on 4/8/19 at 9:56 AM showed resident #62 had visibly wet pants and was taken to the toilet by CNA #2. After toileting the resident the CNA redressed the resident in the wet pants	F 550	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 F550 1. Resident #24 care plan updated to reflect residents' ability to wear clothes inside out and/or backwards. Resident #8 and #112 changed into clean pants during the survey. Resident #220 catheter bag placed in catheter bag cover during the survey. 2. The Director of Nursing or designee completed an audit to identify others who require the required assistance with dressing. The Director of Nursing or designee completed an audit to identify others who may have concerns related to dignity. The Director of Nursing or designee completed an audit to identify non-compliance with cell phone usage by employees. 3. The Staff Development Coordinator or designee will educate staff on treating residents in a dignified manner specifically dressing, catheter covers and appropriate use of cell phones. 4. The Director of Nursing or designee will randomly audit 10 residents daily, 5 days per week for 90 days to validate dressing and catheter covers needs are met. The Staff Development Coordinator	

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F 550	Continued From page 3	F 550		

and returned him/her to the dining room. During interview with the CNA at that time the CNA stated "It's probably just juice..."

3. Observation in the second floor dining room on 4/7/19 at 6:03 PM showed resident #112 had vomited down the front of his/her shirt and pants, and a staff member took the resident to his/her room. Observation in the hallway near the resident's room on 4/7/19 at 7:44 PM showed the resident was wearing a different shirt, however, his/her pants remained the same and had a stain on the left upper pant leg.

4. Review of the 4/2/19 admission MDS assessment showed resident #220 was admitted to the facility on 3/26/19 with diagnoses which included cancer, pneumonia, and CVA (cardiovascular accident). The resident had a BIMS score of 12/15 (moderate cognitive impairment); had an indwelling catheter; required the extensive assistance of one staff member for transfers, locomotion, dressing, toilet use, and personal hygiene; and required supervision for eating. The following concerns were identified:

a. Observation on 4/8/19 at 5:52 PM showed the resident was in the dining room for the evening meal. CNA #1 was seated across from the resident using her cell phone and not interacting with the resident. Interview with the CNA at that time revealed the resident required assistance back to his/her room and she was waiting for the resident to complete his/her meal.

b. Observation on 4/8/19 at 8:04 AM showed the resident was in the dining room with his/her catheter bag hanging uncovered from the right side of his/her wheelchair.

c. Observation on 4/8/19 at 10:58 AM showed the resident was in the therapy room with his/her

or designee will randomly observe staff to validate appropriate use of cell phones. 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 550	Continued From page 4 catheter bag uncovered. There were 10 additional residents and staff present in the therapy room at that time. d. Observation on 4/8/19 at 12:16 PM showed the resident was in the dining room for the noon meal with his/her catheter bag uncovered. e. Interview on 4/10/19 at 9:11 AM with the DON revealed it was her expectation catheter bags be placed in a privacy bag to promote dignity. In addition, she stated it was the facility's policy that staff not use their personal cell phones during working hours, except for an emergency.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		5/15/19

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F 584	Continued From page 5 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and family and staff interview, the facility failed to implement measures to effectively eliminate odors in 1 of 37 sample resident rooms (#24) observed for environmental concerns. The findings were: During observation on 4/7/19 at 4:45 PM an odor was detected emanating from a room shared by resident #24 and his/her roommate. Inside the room the strong odor was a mixture of urine and neglected personal hygiene. The odor was present again on 4/8/19 and 4/9/19. Observation of the room every day from 4/7/19 to 4/11/19 showed a "Caution Wet Floor" sign was positioned in the hall near the entrance door. Interview on 4/8/19 at 2 PM with a visiting family member revealed s/he and other family members were concerned about the offensive odor emanating from the room. Interview on 4/9/19 at 10:55 AM with the special care director revealed	F 584	F584 1. Resident #24 room is free of odor. 2. The Director of Environmental Services or designee will audit resident rooms to validate rooms are free of odors. 3. The Staff Development Coordinator or designee educated staff to validate staff are taking appropriate measures to effectively eliminate odors in resident rooms. 4. The Director of Environmental Services or designee will randomly audit 5 resident rooms daily, 5 days per week for 90 days to validate rooms are free from odors. 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	

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F 584	Continued From page 6 one of the residents who resided in the room was confused and frequently urinated in inappropriate areas of the room and the roommate was noncompliant with scheduled baths/showers. She also stated the "Caution Floor Wet" sign was permanently posted outside the room due to the confused resident's behavior of voiding in inappropriate areas. At that time, the special care director stated she would have to talk with the housekeeping staff about doing something more than the usual room cleaning for this room.	F 584	achieved or sustained as directed by the committee.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		5/15/19

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F 657	Continued From page 7 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, family and staff interview, and policy review, the facility failed to revise the care plan to reflect resident needs for 3 of 37 residents (#63, #71, #108) reviewed. The findings were: 1. Review of the 2/9/19 quarterly MDS assessment and the 3/1/19 significant change MDS assessment showed resident #63 wandered 4 to 6 days of the 7-day look-back period. The following concerns were identified: a. Observation on 4/8/19 at 9:25 AM showed the resident had a WanderGuard (device to alert staff of possible elopement) attached to his/her right ankle. b. Review of a nurse's note dated 3/22/19 revealed the resident was exit seeking and a WanderGuard and been placed. c. Review of the care plan, last revised 2/19/19, failed to show interventions to address the resident's wandering or the use of the WanderGuard. d. Interview on 4/11/19 at 11:18 AM with the DON confirmed the care plan did not address the resident's wandering or the use of the WanderGuard. 2. Review of the 3/5/19 quarterly MDS assessment showed resident #71 was admitted to the facility on 11/13/18 and had diagnoses which included dementia, anxiety, arthritis, and hypertension. Further review showed the resident required the extensive assistance of 2 staff for bed mobility, transfers, and toileting. The	F 657	F657 1. Resident #63 wander guard has been care planned. Resident # 71 attempts to crawl out of bed and her preference for sleeping in a recliner has been care planned. Resident #108 discharged. 2. The MDS Coordinator or designee will complete an audit of residents with wander guards, residents whom sleeping preference is in a recliner and residents with treatment order for ace wraps to validate the care plan is updated. 3. The Staff Development Coordinator or designee will educate staff to validate that residents with wander guards, residents whom sleeping preference is in a recliner and residents with treatment order for ace wraps have an appropriate care plan. 4. The MDS Coordinator or designee will monitor monthly for 90 days for Residents with wander guards, residents whom sleeping preference is in a recliner and residents with treatment order for ace wraps to validate the care plan is updated. 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 657	Continued From page 8	F 657		

following concerns were identified:

a. Observation on 4/7/19 at 5:44 PM showed the resident had a bruised area on the right side of his/her face.

b. Interview on 4/8/19 at 10:27 AM with the resident's son revealed the resident had fallen twice since admission; the first time the resident sustained a broken hip. The son stated the latest fall happened a week ago and the resident went to the emergency room and received stitches above the eyebrow. The son stated the resident was sleeping in the recliner and fell out.

c. Review of a nurse progress note dated 4/2/19 showed "the resident had been sleeping in the recliner and at 3:45 AM the resident was found on the floor in front of the recliner....the resident sustained a laceration about the right eyebrow, and pressure was applied...". Additional review of the nurse progress note showed the resident was transferred to the hospital on 4/2/19 at 10 AM and returned during the evening.

d. Interview with LPN #1 revealed the resident was kept safe by providing 1:1 care to the resident.

e. Interview on 4/11/19 at 9:09 AM with CNA #3 revealed the resident slept in the recliner and the staff reclined the chair back because the resident was unable to. The CNA further stated the resident did not sleep in his/her bed and had not slept in the bed since admission.

f. Interview on 4/11/19 at 2:27 PM with HSA #1 revealed when staff tried to lay the resident down in bed s/he immediately tried to crawl out. She stated staff transferred the resident to the recliner, provided a pillow and blanket and s/he fell asleep. She further stated when the resident needed something s/he yelled out.

g. Review of the care plan showed "4-2-16 fall from recliner with laceration above right

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F 657	Continued From page 9	F 657		

eyebrow...keep pillows on each side in recliner to increase comfort-anticipate and meet needs...." Interview on 4/10/19 at 10:35 AM with LPN #2 revealed she added the statement to the care plan on the evening of 4/9/19. She further stated staff were educated to add pillows while the resident was in the recliner, due to resident's size and dry elbows. Further review of the care plan failed to show planning related to the resident's preference to sleep in the recliner and attempts to crawl out of bed.

h. Review of the Fall Evaluation and Management policy dated 3/18 showed "...Reviews and updates the care plan with newly identified interventions as needed...".

3. Review of the 3/8/19 admission MDS assessment showed resident #108 was admitted to the facility on 3/1/19 with diagnoses which included coronary artery disease, atrial fibrillation, diabetes mellitus, and cellulitis. The resident had a BIMS score of 14/15 (cognitively intact). The following concerns were identified:

a. Review of a physician communication form dated 3/24/19, from a RN at the facility, showed the resident had bilateral lower extremity edema (BLE) and the resident had reported when s/he was at home that his/her legs were wrapped every day. The RN requested an order for ACE wraps (bandages used to control swelling) for BLE to be on in the morning and off at bedtime, wrapped from toes to knees. The physician responded with an order of ACE wraps, as requested by the RN.

b. Review of the resident's care plan last revised 3/14/19 showed the resident had a diagnosis of congestive heart failure with a goal to be free of peripheral edema through the next review date. Further review of the interventions

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F 657	Continued From page 10 showed no evidence the use of the ACE wraps was addressed. c. Interview on 4/11/19 at 1:45 PM with the MDS coordinator revealed she was unaware of the addition to the resident's treatment plan and verified the care plan had not been revised.	F 657		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure services were provided by qualified persons for 1 random observation which affected resident #14. The findings were: Review of the 4/4/19 quarterly MDS assessment showed resident #14 had a BIMS score of 15/15 (cognitively intact) and had diagnoses which included heart failure, pneumonia, diabetes mellitus, COPD (chronic obstructive pulmonary disease), respiratory failure, dyspnea, and long term (current) use of systemic steroids. Further review showed the resident received oxygen therapy. The following concerns were identified: a. Observation on 4/8/19 at 10:35 AM showed CNA #4 and CNA #5 in the resident's room adjusting the oxygen concentrator flow regulator. The CNAs brought in 2 different 5 liter concentrators and attempted to adjust the oxygen	F 659	F659 1. Resident #14 care plan has been updated to reflect nurses will adjust oxygen flow per orders to meet resident needs. 2. The Director of Nursing or designee will complete an audit of residents whom have an oxygen orders to validate that the care plan reflects nurses will adjust oxygen flow per orders to meet resident needs. 3. The Staff Development Coordinator or designee will educate staff to validate that the care plan reflects the ordered amount of liter flow and oxygen flow be adjusted by a licensed nurse. 4. The Director of Nursing or designee will randomly observe three (3) residents weekly for 90 days to validate that the care plan reflects the ordered amount of	5/15/19

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GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 659	Continued From page 11 flow to 5 liters on each one. CNA #5 stated to unit manager #2 "the liter dose won't turn up past 3 liters." b. Interview with unit manager #2 on 4/8/19 at 11 AM revealed the resident had a history of COPD; was having trouble breathing and his/her oxygen saturation was decreasing. c. Interview on 4/11/19 at 11:30 AM with the DON revealed the oxygen liter dose was a physician order for the nurse to administer. Further, it was the facility's expectation CNAs would not adjust oxygen flow rate.	F 659	liter flow and oxygen flow be adjusted by a licensed nurse. The Staff Development Coordinator will randomly observe/ interview three (3) CNAs weekly to validate that understanding that oxygen flow be adjusted by a licensed nurse. 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 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and resident and staff interview, the facility failed to provide services to maintain personal and/or oral hygiene to 15 of 37 sample residents (#5, #11, #24, #50, #51, #54, #67, #75, #80, #88, #91, #103, #108, #109, #112), reviewed. The findings were: 1. Review of the 2019 March and April Resident Functional Performance bathing documentation for resident #5 showed the resident received a shower on 3/7, and did not receive another shower until s/he received a bed bath on 4/3 (28 days). There was documentation the resident refused showers on 3/19 and 3/26.	F 677	F677 1. Resident #80, #108, and #109 discharged. Resident #5, #11, #24, #50, #51, #54, #88, #103, #112 are being offered a shower/ bed bath twice weekly with acceptance/ refusals documented. Resident #11, #67, #75 are provided routine oral care. 2. The Director of Nursing or designee will complete an audit to assess for other residents who may be affected by deficiency with corrections made. 3. The Staff Development Coordinator or designee will educate staff to validate residents receive adequate provision and	5/15/19

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 _____	C 04/11/2019

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 677	Continued From page 12 2. Review of the 1/8/19 quarterly MDS assessment showed resident #11 had a BIMS score of 8/15 (moderately impaired cognition) and required the extensive assist of 1 for personal hygiene and bathing. The following concerns were identified: a. Observation on 4/8/19 at 4:46 PM showed the resident's teeth were coated with a white substance. Interview with the resident at that time revealed s/he did not brush his/her teeth. b. Review of the care plan revised on 7/23/18 showed the resident was at risk for dental health problems and interventions included "monitor/document report PRN any s/sx of oral/dental problems needing attention." Further review of the care plan showed the resident required assistance with bathing/showering. c. Review of the March 2019 Functional Performance Record showed the resident went from 3/2 to 3/13 without a bath or shower (11 days). Further review showed the resident went from 3/1 to 3/21 without oral care (20 days). d. Interview on 4/11/19 at 11:31 AM with the DON revealed she had educated staff about baths and resident refusals and confirmed the baths were not clearly documented. She further stated staff were educated on oral care and was not sure why residents were not receiving it. 3. Review of the 2/1/19 annual MDS assessment showed resident #24 had moderate cognitive impairment; required supervision with ambulation; required extensive assistance with dressing and was totally dependent on staff for bathing and showering. Review of the care plan, revised 12/27/18, showed s/he was at risk for ADL self-care performance deficit due to dementia, change in cognitive status, vision problems and	F 677	documentation of ADL care. 4. The Director of Nursing or designee will complete a random daily audit of 10 residents per day 5 days per week for 90 days to validate frequency of showers and oral care. 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.	

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	535013	A. BUILDING _____ B. WING _____	C 04/11/2019

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GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 677	Continued From page 13	F 677		

incontinence. Review of the shower schedule showed the resident was scheduled to receive 2 showers/baths weekly. Review of the 3/1/19 to 4/8/19 Resident Functional Performance Record showed the resident did not receive a bath or shower from 3/9/19 to 3/16/19 (7 days). Further review showed no documented refusals.

4. Review of the 2/19/19 quarterly MDS assessment showed resident #50 required the physical assistance of one staff member for bathing. Review of the March 2019 Resident Functional Performance bathing documentation showed the resident had a shower on 3/19 and did not receive another until 3/29 (10 days). Further review showed no evidence the resident had refused a shower during that timeframe.

5. Review of the 2/19/19 quarterly MDS assessment showed resident #51 had severe cognitive impairment and required extensive assistance with bathing and personal hygiene care. Review of the care plan, revised 12/28/18, showed the resident had ADL self-care performance deficit due to dementia; and staff were directed to provide a sponge bath when the resident could not tolerate a full bath or shower. Review of the shower schedule showed the resident was scheduled to receive 2 showers/baths weekly. Review of the 3/1/19 to 4/8/19 Resident Functional Performance Record showed the resident did not receive a sponge bath or shower from 3/7/19 to 3/15/19 (8 days). Further review showed no documented refusals.

6. Review of the 2019 March and April Resident Functional Performance bathing documentation for resident # 54 showed the resident had a shower on 3/1 and did not receive another until

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 _____	C 04/11/2019

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 677	Continued From page 14	F 677		

3/12 (11 days); a shower on 3/18 and did not receive another until 3/24 (6 days); and from 3/24 the resident did not receive a shower again until 4/11 (18 days).

7. Review of the 3/13/19 admission MDS assessment showed resident #67 was admitted to the facility on 3/6/19; had a BIMS score of 15/15 (cognitively intact); and required the total assistance of two staff members for bed mobility and transfers, and the extensive assistance of one staff member for personal hygiene. The following concerns were identified:

a. Interview on 4/8/19 at 11:30 AM with the resident revealed s/he was using mouthwash for oral care because no one had offered to assist him/her with brushing his/her teeth. In addition the resident stated s/he had not brushed his/her teeth since admission and "my mouth feels horrible and my breath stinks."

b. Review of the ADL care plan, initiated on 3/17/19, showed the resident required assistance with grooming/hygiene.

c. Review of the dental care plan, initiated on 3/17/19, showed the resident was at risk for potential dental issues related to decreased/limited mobility. The resident was to "remain free of infection, pain or bleeding in the oral cavity by review date." However, there were no interventions regarding routine oral care.

d. Review of the CNA's Care Directive Form showed the resident had his/her own teeth and required extensive assistance with grooming. In addition, the CNAs were to encourage independence with upper body ADLs.

e. Interview on 4/10/19 at 9:22 AM with the DON revealed she expected oral care to be offered after each meal and the resident assisted as needed.

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 _____	C 04/11/2019

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 677	Continued From page 15	F 677		

8. Random observation of resident care on 4/7/19 at 7:32 PM showed CNA #6 transferred resident #75 to bed without providing oral care and left the room. Interview with the CNA at that time revealed the resident was in bed for the night.

9. Review of the 2019 March Resident Functional Performance bathing documentation for resident #80 showed the resident went without a shower from admission on 3/8/19 until discharge on 3/28/19 (20 days).

10. Review of the 2/28/19 admission MDS assessment showed resident #88 required the physical assistance of one staff member for bathing. Review of the March 2019 Resident Functional Performance bathing documentation showed the resident had a shower on 3/16 and did not receive another until 3/26 (10 days). Further review showed no evidence the resident had refused a shower during that timeframe.

11. Review of the 2/19/19 admission MDS assessment showed resident #91 required the physical assistance of one staff member for bathing. Review of the March 2019 Resident Functional Performance bathing documentation showed the resident had a shower on 3/10 and did not receive another until 3/25 (15 days). Further review showed no evidence the resident had refused a shower during that timeframe.

12. Review of the 2019 February, March, and April Resident Functional Performance bathing documentation for resident #103 showed the resident had a shower on 2/15 and did not receive another until 3/5 (17 days); received a shower on 3/7 and did not receive another until

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	535013	A. BUILDING _____ B. WING _____	C 04/11/2019

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 677	Continued From page 16	F 677		

3/18 (11 days). Interview with resident #103 on 4/7/19 at 5:12 PM revealed s/he was supposed to have received a shower that day, but did not. S/he stated "the hot water must have went out."

13. Review of the 3/8/19 admission MDS assessment for resident #108 showed the resident was admitted on 3/1/19 and did not receive a bath during the 7-day look-back period. Review of the March 2019 Resident Functional Performance bathing documentation for the resident showed the resident had a shower on 3/10 and did not receive another until 3/25 (15 days). Further review showed no evidence the resident had refused a shower during that timeframe.

14. Review of the March 2019 Resident Functional Performance bathing documentation for resident #109 showed the resident had a shower on 3/1 and did not receive another until 3/9 (8 days). Further review showed the resident's next shower was on 3/26 (17 days). There was no evidence the resident had refused a shower during the gaps between shower days.

15. Review of the 2019 March and April Resident Functional Performance bathing documentation for resident #112 showed the resident had a shower on 3/1 and did not receive another until 3/17 (16 days); and received a shower on 4/1 and did not receive another until 4/8 (7 days).

16. Interview on 4/10/19 at 12:41 PM with CNA #7 revealed she was the bath aide for the first floor. In addition, during the timeframe in March when the showers were not being completed she had been pulled to work in other areas of the building and no one had showered the residents

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 _____	C 04/11/2019

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 677	Continued From page 17 in her absence. 17. Interview with the DON on 4/10/19 at 3:25 PM revealed the facility's expectation was for staff to offer residents a shower or bed bath twice a week and document it. If a resident refused 3 times the staff were to notify the nurse. 18. Interview on 4/11/19 at 11:13 AM with the DON revealed she was aware of the gaps between showers and had implemented new shower schedules.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure anti-embolism hose were applied as ordered for 3 of 4 sample residents (#8, #52, #108) with bilateral lower extremity (BLE) edema (swelling). The findings were: 1. Review of the 1/17/19 significant change MDS assessment showed resident #8 was admitted to the facility on 8/17/18 with diagnoses which included coronary artery disease, dementia, and a history of venous thrombosis and embolism.	F 684	F684 1. Resident #8 and #52 care plan has been updated to reflect current lower extremity edema interventions. Resident #8 and #52 are receiving the ordered lower extremity edema interventions with appropriate documentation. Resident #108 discharged. 2. The Director of Nursing or designee will complete an audit of residents with ted hose or ace wrap orders to validate accuracy of the treatment record and care	5/15/19

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 _____	C 04/11/2019

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 684	Continued From page 18 Further review showed s/he had severe cognitive impairment and required extensive to total assistance with all ADLs. Review of the physician's orders showed the physician ordered anti-embolism hose on 3/28/19. The following concerns were identified: a. Observations on 4/7/19 from 4:45 PM to 8:40 PM, on 4/8/19 from 8:50 AM to 2:30 PM, and on 4/9/19 at 10:58 AM showed the resident did not wear anti-embolism hose. Further observation showed the resident's legs appeared edematous. b. Interview on 4/9/19 at 10:58 AM with the DON revealed the hose should have been applied because they usually were provided for the resident within 2 or 3 days of the order. She further stated she did not know why the resident did not have the anti-embolism hose. 2. Review of the 2/19/19 annual MDS assessment showed resident #52 was admitted to the facility on 3/29/12 with diagnoses which included cellulitis, heart failure, dementia, anemia, and diabetes. Further review showed s/he had severe cognitive impairment and required extensive assistance with dressing. Review of the physician's orders showed the physician ordered anti-embolism hose on 11/29/18 to be applied in the morning and removed at night. The following concerns were identified: a. Observations on 4/7/19 from 4:45 PM to 8:40 PM, on 4/08/19 from 8:50 AM to 2:30 PM, and on 4/9/19 at 10:58 AM showed the resident sat in his/her wheelchair and did not wear anti-embolism hose. During the observations the resident's lower legs appeared edematous. b. Review of April 2019 TAR showed the nurses documented the hose were removed at bedtime on 4/3, 4/6, 4/7, 4/8, and 4/9. Further	F 684	plan. 3. The Staff Development Coordinator or designee will educate staff to validate the accuracy of the treatment record, care plan and to validate they are donned on and off per physician orders. 4. The Director of Nursing or designee will complete a random weekly audit of residents with ted hose/ ace wraps to validate the treatment record, care plan and to validate they are donned on and off per physician orders. 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.	

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	535013	A. BUILDING _____ B. WING _____	C 04/11/2019

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 684	Continued From page 19	F 684		

review showed no evidence the anti-embolism hose were applied on the on 4/3, 4/6, 4/7 and 4/9.

c. Interview on 4/10/19 at 3:50 PM with the DON revealed the staff should not document they were applying and removing the hose if they were not. She further stated staff needed to determine whether the resident did or did not need the hose, because if the resident needed them they should be applied as ordered.

3. Review of the 3/8/19 admission MDS assessment showed resident #108 was admitted to the facility on 3/1/19 with diagnoses which included coronary artery disease, atrial fibrillation, diabetes mellitus, and cellulitis. The resident had a BIMS score of 14/15 (cognitively intact). The following concerns were identified:

a. Observation of the resident on 4/7/19 at 5:22 PM showed the resident was lying in bed and the resident's lower legs appeared edematous. The resident was not wearing compression stockings nor were they wrapped with ACE wraps (bandages used to control swelling).

b. Observation of the resident on 4/8/19 at 2:24 PM showed the resident was sitting in his/her recliner. The resident's legs appeared swollen and s/he was not wearing compression stockings nor were the resident's legs wrapped with ACE wraps.

c. Review of a physician communication form dated 3/24/19 showed the resident had bilateral lower extremity edema (BLE) and the resident had reported when s/he was at home his/her legs were wrapped every day. The facility requested an order for ACE wraps to the BLE to be on in the morning and off at bedtime, wrapped from toes to knees. The physician responded with an order of ACE wraps as requested.

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 _____	C 04/11/2019

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 684	Continued From page 20 d. Observation of the resident on 4/10/19 at 12:12 PM showed the resident's legs were wrapped with ACE wraps. Interview with the resident at that time revealed s/he had to "belly-ache" about the wraps and then staff had wrapped his/her legs "yesterday afternoon and again this morning." e. Review of the March 2019 TAR showed documentation the ACE wraps had been donned and doffed, as ordered, on 3/30 and 3/31. Review of the April 2019 TAR showed documentation the ACE wraps were donned and doffed, as ordered, from 4/1 AM through 4/10 AM. f. Review of an April 2019 "clarification" TAR showed the ACE wraps were not applied during the month of April until the morning of 4/10/19. g. Interview with unit manager #1 on 4/10/19 at 12:17 PM revealed the resident's edema was a chronic problem and was worse when s/he was up in a chair all day. In addition, she stated the resident was on medication for the edema, had orders for ACE wraps, and was encouraged to elevate his/her feet when sitting. h. Interview with the DON on 4/11/19 at 11:18 AM revealed she was unsure why there was a discrepancy between the TAR and surveyor observations. Further, she stated a new nurse was orienting on the first floor and she had attempted to contact the nurse for clarification. Interview with the DON on 4/11/19 at 4:28 PM revealed the orientating nurse had been contacted and verified the ACE wraps had not been applied as ordered.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		5/15/19

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 _____	C 04/11/2019

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 686	Continued From page 21 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure 1 of 12 sample residents with pressure ulcers (#8) consistently received treatments in accordance with physician orders. The findings were: Review of the 1/17/19 significant change MDS assessment showed resident #8 had severe cognitive impairment, required extensive or total assistance with all ADLs and was at risk for developing pressure ulcers. Further review showed the resident was always incontinent of bladder and bowel and did not have pressure ulcers. Review of the care plan interventions, revised 8/29/18, showed staff were directed to check the resident frequently, assist with toileting as needed, and complete weekly and as needed skin assessments. The following concerns were identified: a. Observation on 4/7/19 from 4:45 PM to 8:40 PM (almost 4 hours) showed the resident sat in his/her wheelchair in the dining/common area. During the continuous observation staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care.	F 686	F686 1. Resident #8 is receiving appropriate wound care per physicians' orders. 2. The Director of Nursing or designee will complete an audit of residents with pressure ulcers to assess for others affected by deficiency. 3. The Staff Development Coordinator or designee will educate staff to validate treatments are done per physicians' orders, related to treatments. 4. The Director of Nursing or designee will complete a random visual weekly audit for 90 days to validate that the treatments are done per physicians' order. 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 22 Observation at 8:40 PM showed CNA #6 and CNA #8 transferred the resident to bed, removed his/her urine- and feces-soiled disposable brief, then provided incontinence care. At that time, an uncovered pressure ulcer on the resident's coccyx area was observed. This area was moist, pink and approximately dime-sized. b. Continuous observation on 4/8/19 from 8:50 AM to 2:30 PM (5 hours and 50 minutes) showed the resident sat in his/her wheelchair in the dining/common area. During the observation staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care until the resident was transferred to bed at 2:30 PM. At that time CNA #2 and CNA #9 removed the urine-soaked disposable brief and exposed the uncovered pressure ulcer on the resident's coccyx area. c. Review of the wound care treatments showed the current treatment was to cleanse the area with wound cleanser, pat dry, apply skin prep, cover with hydrocolloid and change every 3 days and as needed. Further review showed this treatment was ordered on 3/10/19 for the area assessed as an "unstageable pressure injury." d. Review of the March 2019 to April 2019 nursing daily progress notes showed the area remained unchanged. e. Interview on 4/9/18 at 11:21 AM with the wound care nurse revealed the pressure ulcer should have been covered with the hydrocolloid dressing. She also stated the facility had a system for reporting and documenting changes in wounds and pressure ulcers, but did not have a system for ensuring the nurses provided the treatments consistently as ordered.	F 686		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		5/15/19

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 _____	C 04/11/2019

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 690	Continued From page 23 §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, medical record review, and staff interviews, the facility failed to ensure	F 690	F690 1. Resident #110 discharged. Resident	

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 _____	C 04/11/2019

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 690	Continued From page 24 toileting and incontinence care were provided as needed for 4 of 6 sample residents (#8, #40, #52, #110) reviewed for incontinence. The findings were: 1. Review of the 1/17/19 significant change MDS assessment showed resident #8 had severe cognitive impairment and required extensive or total assistance with all ADLs including toileting and personal hygiene care. Further review showed the resident was always incontinent of bladder and bowel. Review of the care plan interventions, revised 8/29/18, showed staff were directed to check the resident frequently and assist with toileting as needed. The following concerns were identified: a. Observation on 4/7/19 from 4:45 PM to 8:40 PM (almost 4 hours) showed the resident sat in his/her wheelchair in the dining/common area. During the continuous observation staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care. Observation at 8:40 PM showed CNA #6 and CNA #8 transferred the resident to bed, removed his/her urine- and feces-soiled disposable brief, then provided incontinence care. At that time, an uncovered pressure ulcer on the resident's coccyx area was observed. b. Continuous observation on 4/8/19 from 8:50 AM to 2:30 PM (5 hours and 50 minutes) showed the resident sat in his/her wheelchair in the dining/common area. During the observation staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care until the resident was transferred to bed at 2:30 PM. At that time CNA #2 and CNA #9 removed the urine-soaked disposable brief and exposed the uncovered pressure ulcer on the resident's coccyx area.	F 690	#8, #52, #40 are receiving appropriate incontinence care. 2. The Director of Nursing or designee completed an audit to assess for others affected by deficiency to ensure appropriate incontinence care is provided. 3. The Staff Development Coordinator or designee educated staff 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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	535013	A. BUILDING _____ B. WING _____	C 04/11/2019

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 690	Continued From page 25	F 690		

2. Review of the 3/21/19 quarterly MDS assessment showed resident #110 had severe cognitive impairment and required extensive or total assistance with all ADLs including toileting and personal hygiene care. Further review showed the resident was always incontinent of bladder and bowel. Review of the care plan interventions for ADL self-care performance deficit, revised 2/1/19 showed the resident required assistance with toilet use and grooming/hygiene. The following concerns were identified:

a. Observation on 4/7/19 from 4:45 PM to 9:45 PM, showed the resident rested in bed. During the observation staff fed the resident and periodically offered fluids. However, during the 5 hour observation, staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care until 9:45 PM. At that time, incontinence care provided by CNA #6 and CNA #8 included removing the disposal brief worn by the resident and changing the urine-soiled bed linen.

b. Observation on 4/8/19 from 8:50 AM to 1 PM (over 4 hours) showed the resident rested in bed without being provided incontinence care or toileting assistance. At 1 PM, continuous observation showed CNA #2 and CNA #9 removed the urine-soiled disposable brief and bed linen when they provided incontinence care for the resident.

3. Review of the 2/19/19 annual MDS assessment showed resident #52 had a BIMS score of 5 (indicating cognitive impairment); required extensive assistance with toileting and personal hygiene care; and was always incontinent of bowel and bladder. Review of the

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 _____	C 04/11/2019

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 690	Continued From page 26	F 690		

care plan, revised 1/5/19, showed the resident had ADL self-care performance deficit due to weakness and required assistance with personal hygiene care and toileting. Observation on 4/7/19 from 4:45 PM to 9:30 PM (over 5 hours) showed the resident sat in his/her wheelchair in the dining/common area. During the continuous observation staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care. Observation at 9:30 PM showed CNA #6 and the DON transferred the resident to bed, removed his/her urine- and feces-soiled disposable brief, and provided incontinence care.

4. Review of the 2/14/19 quarterly MDS assessment showed resident #40 had severe cognitive impairment and required limited assistance with transfers, toileting, and personal hygiene care. Further review showed the resident had frequent urine incontinence and occasional bowel incontinence. Review of the care plan interventions for bladder incontinence due to dementia and decreased mobility, revised 2/25/19, showed staff were directed to clean peri-area with each incontinence episode and ensure the resident had an unobstructed path to the bathroom. Further review showed instructions to monitor for signs and symptoms of a urinary tract infection. Observation on 4/8/19 at 8:50 AM showed the resident was sitting on the bedside. At that time wet urine-stained areas on the groin and buttocks areas were observed on his/her pajamas. Continuous observation showed the resident wore the wet pajamas until 10:34 AM. At that time CNA #2 and CNA #9 assisted the resident to the bathroom and removed his/her wet brief and pajamas.

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 _____	C 04/11/2019

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 690	Continued From page 27 5. Interview on 4/8/19 at 2:30 PM with CNA #2 and CNA #9 revealed they tried to check and toilet residents every two hours, but they were unable to get to all the residents in a prompt manner when there was an insufficient number of staff on duty. Interview on 4/9/19 at 10:55 AM with the Special Care Director revealed she routinely helped the CNAs, but she was not a nurse and could not assist with toileting or personal care needs.	F 690		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		5/15/19

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 _____	C 04/11/2019

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 725	Continued From page 28 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interviews, staff interview, review of the facility assessment, and review of facility staffing documentation, the facility failed to ensure an adequate number of staff was provided to meet resident needs. The census was 118. The findings were: Review of the facility assessment staffing plan showed the total number of nurses and CNAs required to meet basic staffing needs was 10 licensed nurses and 18 CNAs. Non-licensed and non-certified staff were not separately accounted for. The following concerns were identified: 1. Review of the facility staffing sheets from 2/1/19 through 2/28/19 revealed the facility failed to have the minimum required nurse staffing on 22 of the 28 days (78%). 2. Review of the facility staffing sheets from 3/1/19 through 3/31/19 revealed the facility failed to have the minimum required nurse staffing on 28 of the 31 days (90%). 3. Review of the facility staffing sheets from 4/1/19 through 4/7/19 revealed the facility failed to have the minimum required nurse staffing on 5 of the 7 days (71%). 4. Review of the facility staffing sheets from 2/1/19 through 4/7/19 revealed the facility failed to have the minimum required CNA staffing on all days reviewed (100%).	F 725	F725 1. No immediate correction can be made for cited inadequate staffing, however, residents' needs are met. An informal meeting was held to discuss staffing and gather ideas for scheduling. As a result, and as discussed during the survey, the facility attendance policy was enforced to reduce staff call ins and in doing so the facility opened nine (9) CNA positions. The facility developed a new schedule for Resident Care Managers to work a full-time schedule on the floor instead of scheduling them day by day and to reassign some of their managerial responsibilities to offset the staffing needs. Furthermore, CNA team member's picked up extra shifts and in most instances are scheduled into overtime. Welcome bonus' to the facility are offered for recruitment and retention efforts. Additional pick up shift bonus are offered as needed when staffing levels dictate. 2. All residents are at risk for gaps in care due to cited inadequate staffing levels. The facility has an active recruitment and retention program and interviews each qualified applicant. The facility has hired two (2) new CNAs that have started at the facility, one (1) CNA pending a background checks, have transitioned five (5) CNAs from PRN/ Part time to Full time and have sponsored 4 unlicensed assistive personnel into a CNA program. The facility continues to	

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 _____	C 04/11/2019

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 725	Continued From page 29 5. Interview on 4/8/19 at 3:30 PM with 7 residents revealed they had concerns about lengthy wait times for call lights to be answered, and lack of showers. 6. Interview on 4/8/19 at 2:26 PM with a family member of resident #77 revealed there was no system for getting residents up and the only time the resident's face was washed was during a bath. She further stated there was only 1 CNA for 19 residents. 7. Interview on 4/10/19 at 2:11 PM with a family member of resident #15 revealed the resident did not receive a bath during the first two weeks after s/he was admitted. The family member stated s/he felt the staff was overwhelmed with care, especially in the evening, when they were getting residents to bed and other residents were unattended in the dining room. The spouse also stated the resident's room had not been cleaned in 3 days. 8. Interviews with facility staff revealed the following: a. Interview on 4/9/19 at 4:07 PM with LPN #1 revealed only 2 CNAs provided care for each hall and no bath aide. She stated baths got missed , fluids were not passed to residents, and residents were not assisted with meals. She stated she did not understand the staffing related to the numbers, and why resident acuity did not factor into staffing. She added there were residents who required total care, were a total lift for transfers, and those residents took additional time and extra staff. She further stated there were nights when only one CNA worked in the secure unit. b. Interview on 4/9/19 at 4:46 PM with HSA #1 revealed she was scheduled with a CNA in the	F 725	advertised for unlicensed assistive personnel and will hire until such time the facility can send them to a community nurse aide training program. The facility is currently interviewing applicants at this time. Additionally, the IDT meets daily, Monday through Friday, to discuss staffing and plans for coverage. 3. Nursing staff will be educated by the Director of Nursing or designee about changes in scheduling and recruitment bonuses and should they feel that they can't provide the required care to residents, they should immediately notify the Resident Care Manager or the Director of Nursing so that additional resources can be deployed as needed. The Director of Nursing or designee will provide staff education to validate understanding. 4. The Executive Director or designee will audit five (5) random shifts per week to validate staffing levels are consistent with the facility center assessment. The Executive Director or designee will interview five (5) random residents regarding timely call light response time, as well as overserve five (5) random call lights per week. The Executive 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.	

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 _____	C 04/11/2019

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 725	Continued From page 30	F 725		

secure unit, but when the CNA took a break she was left alone with the residents. She stated if an unsafe situation occurred she pressed the "HELP" button, which is located by the nurse's station by the clock. She stated she had been alone in a room with an upset resident, and she had to wait for the resident to calm down, because she had no way to get help.

c. Interview on 4/10/19 at 4:08 PM with HSA #1 revealed she was vomiting and tried to call in sick and the facility told her she had to work. She added she talked to the DON who told her to find her own coverage if she was sick. The HSA stated she did not have any of the other staff phone numbers at home.

d. Interview on 4/8/19 at 2:30 PM with CNA #2 and CNA #9 revealed they tried to check and toilet residents every two hours, but they were unable to get to all the residents in a prompt manner when there was an insufficient number of staff on duty.

e. Interview on 4/11/19 at 8:28 AM with the infection control nurse revealed she had been "working on the floor" and had not been able to devote time to all of the infection control nurse duties. She stated she started the surveillance and periodic audit system for monitoring dressing changes, ADLs, and hand hygiene, but the most current audits were completed in August 2018. She stated she started developing the antibiotic stewardship program, but it had not been fully implemented.

f. Interview on 4/10/19 at 12:41 PM with CNA #7 revealed she was the bath aide for the first floor. During the timeframe in March when the showers were not being done she had been pulled to work in other areas of the building and no one had showered the residents in her absence.

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 _____	C 04/11/2019

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 725	Continued From page 31	F 725		

9. Staff inability to respond promptly to residents's toileting and incontinence needs was noted during the following observations:

a. Observation on 4/7/19 from 4:45 PM to 8:40 PM (almost 4 hours) showed resident #8 sat in his/her wheelchair in the dining/common area. During the continuous observation staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care until 8:40 PM when CNA #6 and CNA #8 provided urine and fecal incontinence care. Continuous observation on 4/8/19 from 8:50 AM to 2:30 PM (5 hours and 50 minutes) showed the resident sat in his/her wheelchair in the dining/common area. During the observation staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care until 2:30 PM.

b. Observation on 4/7/19 from 4:45 PM to 9:45 PM, showed resident #110 rested in bed. During the observation staff fed the resident and periodically offered fluids. However, during the 5 hour observation, staff did not offer or provide toileting assistance, check for incontinence, or provide incontinence care until 9:45 PM. Observation on 04/08/19 from 8:50 AM to 1 PM (over 4 hours) showed the resident rested in bed without being provided incontinence care or toileting assistance. At 1 PM, continuous observation showed CNA #2 and CNA #9 removed the urine-soiled disposable brief and bed linen when they provided incontinence care for the resident.

c. Observation on 4/7/19 From 4:45 PM to 9:30 PM (over 5 hours) showed resident #52 sat in his/her wheelchair in the dining/common area. During the continuous observation staff did not offer or provide toileting assistance, check for

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 _____	C 04/11/2019

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 725	Continued From page 32	F 725		

incontinence, or provide incontinence care. Observation at 9:30 PM showed CNA #6 and the DON transferred the resident to bed, removed his/her urine- and feces-soiled disposable brief, and provided incontinence care.

d. Observation on 4/8/19 at 8:50 AM showed resident #40 was sitting on the bedside. At that time wet urine-stained areas on the groin and buttocks areas were observed on his/her pajamas. Continuous observation showed the resident wore the wet pajamas until 10:34 AM. At that time CNA #2 and CNA #9 assisted the resident to the bathroom and removed his/her wet brief and pajamas.

10. Please refer to F677 for details of concerns regarding resident showers and oral hygiene.

11. Interview with the staffing coordinator on 4/11/19 at 12:21 PM revealed the PPD was determined by the facility's corporation and the NHA and they gave her the number. She stated HSA (non-licensed, non-certified staff members) hours were figured in with the nursing hours. She confirmed the facility was short-staffed, and the past couple months had been terrible because of illness. She also stated the management staff helped on the resident units.

8. Interview on 4/11/19 at 2:15 PM with the NHA confirmed HSA hours were counted with nursing hours. She also stated when staffing was critical all managers were pulled to work on the resident units. She stated they have had turnover due to holding staff accountable to the attendance policy. She stated the facility currently had 9 CNA position openings and 4 full-time nursing position openings. She stated they monitored potential admissions and did not accept residents with

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 _____	C 04/11/2019

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 725	Continued From page 33 higher acuity.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records 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, medical record review,	F 755	F755	5/15/19

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 _____	C 04/11/2019

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 755	Continued From page 34 and staff interview, the facility failed to provide medications to meet resident needs for 1 of 37 sample residents (#108). The findings were: 1. Review of the 3/8/19 admission MDS assessment showed resident #108 was admitted to the facility on 3/1/19 with diagnoses which included diabetes mellitus. The following concerns were identified: a. Review of a nurse's note dated 3/8/19 and timed 3:15 AM showed the resident was found unresponsive with a blood glucose level of 58 mg/dl. The physician was notified; one dose of glucagon was administered, and the resident regained consciousness. b. Review of a nurse's note dated 3/8/19 and timed 5:45 PM showed the resident was lethargic at 5 PM and had a blood glucose level of 35 mg/dl. Glucagon was administered. c. Review of a nurse's note dated 3/9/19 and timed 6:10 PM showed the resident was unresponsive with a blood sugar of 44 mg/dl. The physician was called and one dose of glucagon was administered. After the glucagon was administered the resident was still unresponsive and his/her blood glucose level was 53 mg/dl. The physician was notified and an additional dose of glucagon was ordered. However, no glucagon was available and the resident was sent to the emergency department. d. Observation of the 2nd floor medication storage room on 4/10/19 at 10:47 AM showed 1 expired emergency kit dated 12/18. Interview at that time with the LPN #3 confirmed the medication was expired, and was available for resident use. She revealed it was the glucagon in the kit that had expired. 2. Interview on 4/10/19 at 10:42 AM with unit	F 755	1. Resident #108 discharged. Expired Medication from E-kit was discarded immediately upon survey finding. 2. The Director of Nursing or designee completed an audit of glucagon orders to validate medication availability. The Director of Nursing or designee completed an audit of medication carts/ storage to validate that medications are labeled. 3. The Staff Development Coordinator or designee educated nurses regarding ordering glucagon for all residents with a glucagon order to validate availability of glucagon. 4. The Director of Nursing or designee will complete a random weekly audit of 5 residents for 60 days of residents with glucagon orders to validate Glucagon availability. 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 755	Continued From page 35 manager #1 revealed the facility had identified a problem with the nurses not ordering medications properly. She further stated the error was in the process of being corrected. 3. Interview on 4/11/19 at 11:13 AM with the DON revealed she had recognized there was a problem with the availability of the glucagon. She had obtained new physician orders so each diabetic resident would have glucagon available and also placed 3 doses in the Cubex (electronic medication storage unit). In addition some of the new nurses, including herself, had not been granted access to the Cubex, but this had been corrected. 4. Interview with DON on 4/11/19 at 11:39 AM revealed it was the expectation of the facility for nursing staff to get the medication from the Cubex, if needed, or call the backup pharmacy to get the medication until the order arrived.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		5/15/19

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F 761	Continued From page 36 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure medications were labeled in accordance with professional principles in 1 of 3 medication carts (1st floor medication cart). The findings were: Observation on 4/10/19 at 11 AM of the 1st floor medication cart showed one glucagon container without a pharmacy label on it. The container showed white residue where a label appeared to have been. Interview at that time with unit manager #1 revealed the glucagon belonged to a resident that had been discharged, and confirmed it was unlabeled.	F 761	F761 1. The expired medication from 1st floor medication cart was discarded immediately upon finding during the survey finding. 2. The Director of Nursing or designee completed an audit of medication carts/ storage to validate that medications are labeled. 3. The Staff Development Coordinator or designee educated facility nurses regarding regular checks of medication carts/ storage to validate that expired medications are discarded and medications are labeled. 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 and labeled. 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	

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F 761	Continued From page 37	F 761	committee.	
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, manufacturer's instructions, and review of the 2017 food code, the facility failed to ensure proper dating and labeling of pre-thickened beverage products in 4 of 5 food storage areas (kitchen, first floor, third floor, Reflections unit). The findings were: 1. Observation on 4/7/19 at 4:35 PM of the Victory refrigerator in the main kitchen and again with the certified dietary manager on 4/9/19 at 4:05 PM showed 7 open cartons of pre-thickened beverages and 2 open containers of thickened	F 812	F812 1. The Dietary Manager discarded thicken liquids not dated and labeled immediately upon survey findings. 2. The Dietary Manager or designee audited facility refrigerators to validate thicken liquids not dated and labeled and disposed of per regulation. 3. The Dietary Manager or designee will educate staff to validate that all opened thickened liquids are dated and disposed of per regulation. 4. The Dietary Manager or designee will	5/15/19

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F 812	Continued From page 38 dairy drink were not labeled with an open date. 2. Observation on 4/7/19 at 6:22 PM of the refrigerator located on the first floor showed 2 open cartons of pre-thickened liquid containers and 1 open container of thickened dairy drink were not labeled with an open date. 3. Observation on 4/10/19 at 4:55 PM of the refrigerator located in the Reflections unit showed 2 open cartons of thickened dairy drink were not labeled with an open date. 4. Observation on 4/10/19 at 5 PM of the refrigerator located on the third floor showed 1 open carton of thickened dairy drink was not labeled with an open date. 5. Interview on 4/9/19 at 4:05 PM with the certified dietary manager confirmed the open cartons of thickened beverages were not labeled with an open date. 6. Review of the product label of the pre-thickened beverages showed the product was good for 7 days after opening if refrigerated. In addition, review of the manufacturer's instructions for the thickened dairy drink showed "once opened, recap, refrigerate and use within 48 hours." 7. According to Food Code 2017, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the	F 812	audit facility refrigerators weekly for 60 days to validate thicken liquids are dated and disposed of per regulation. 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 39 PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days."	F 812		
F 880 SS=F	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, 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	F 880		5/15/19

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F 880	Continued From page 40 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. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure effective infection control practices were followed during for 1 random observation. The findings were: Observation on 4/10/19 at 2:32 PM showed the	F 880	F880 1. The Wound Care Nurse received appropriate wound care technique for wound care, proper hand washing technique and appropriate donning on and doffing off PPE education. There are no	

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F 880	Continued From page 41 wound nurse performed a dressing change on resident #103's pressure injury. The following concerns were identified: a. Observation showed after the nurse finished the removal of the old dressing and cleaned her hands to do the clean dressing. The nurse then pulled clean gloves out of her pocket and donned them. b. The wound nurse picked up a packet of skin prep off of the over-bed table and then reached into her pocket and retrieved a pair of scissors to cut the packet. She then put the scissors down on the table. c. The wound nurse dropped a skin prep towelette on floor; picked it up and threw it in the trash bag. She proceeded, with the same gloves, to pack the open wound with wet gauze. d. The wound nurse then picked up the scissors to cut the gauze and set them back down on the table. e. While holding the gauze in place with the same gloves, the nurse retrieved a flashlight from her pocket to look at the skin. The nurse put the flashlight back in her pocket and finished dressing the wound. Interview at that time with the nurse revealed it did not occur to her the pocket was not clean. f. Interview with the DON on 4/10/19 at 3:25 PM revealed it was the facility's expectation for wound care to be completed in a clean procedure.	F 880	negative effects to resident #103 involved during this observation. 2. The Director of Nursing or designee completed audit to assess for other infection control concerns related to wound care. 3. The Staff Development Coordinator or designee provided education to staff to validate proper hand washing technique, appropriate wound care technique and appropriate donning on and doffing off PPE. 4. The Staff Development Coordinator or designee will randomly audit five (5) staff members weekly for 90 days to validate either an appropriate dressing change 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.	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881		5/15/19

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F 881	Continued From page 42 a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of the antibiotic stewardship policy and procedure and staff interview, the facility failed to develop and implement an active and effective antibiotic stewardship program. The census was 118. The findings were: Interview on 4/11/19 at 8:28 AM with the infection preventionist revealed she had been "working on the floor" and had not been able to devote time to all of the infection control duties. She stated she started the surveillance and periodic audit system for monitoring wound dressing changes, ADLs, and hand hygiene, but the most current audits were completed in August 2018. She stated she started developing the antibiotic stewardship program, but it had not been fully implemented. She also confirmed the program did not include active participation from prescribing practitioners and pharmacist. Review of the antibiotic stewardship program forms, documentation, and monitoring records showed an effective system for tracking and identifying appropriate antibiotics and reviewing laboratory sensitivity reports. However, the infection control nurse was unable to provide evidence the following sections of the Antibiotic Stewardship Program policy and procedure, published September 2017, had been operationalized: a. Protocols that identify what infection assessment tools or management algorithms to be used for one or more infections. b. A process for a periodic review of	F 881	F881 1. The Staff Development Coordinator in combination with the Director of Nursing received Antibiotic stewardship education. 2. The Director of Nursing or designee reviewed the Antibiotic Stewardship Program to validate it included infection identification tools, review of antibiotics used by physicians and feedback. 3. The Staff Development Coordinator or designee provided education to staff to validate staff are utilizing the tools for antibiotic stewardship. 4. The Staff Development Coordinator or designee will randomly audit up to five (5) infections per month to validate it included infection identification tools, review of antibiotics used by physicians and feedback. 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 881	Continued From page 43 antibiotic use by prescribing practitioners: c. A system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data, and prescribing practices for the prescribing practitioner.	F 881		