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 04/14/2022

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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 4/11/22 to 4/14/22. Also reviewed in the course of the survey was complaint intakes WY00003388 and WY 00003394. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted from 4/11/22 to 4/14/22. Based upon the findings of the survey team, it was determined that no deficiencies were identified pertaining to the Omnibus COVID-19 Health Care Staff Vaccination requirements. The following common abbreviations are used throughout this document: ADL- Activities of Daily Living CNA- Certified Nurse Aide DNS- Director of Nursing Services MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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,	F 677	Preparation and execution of the	4/22/22

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

Electronically Signed | 05/06/2022

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F 677	Continued From page 1 and staff and resident interview, the facility failed to ensure bathing was provided as scheduled for 4 of 14 sample residents (#10, #29, #43, #312) who required assistance with bathing. The findings were: 1. Review of the 1/15/22 admission MDS assessment showed resident #10 was admitted to the facility on 1/9/22 with diagnoses that included multiple sclerosis, repeated falls, difficulty walking, muscle weakness, fracture of unspecified part of neck of left femur, and need for assistance with personal care. The resident was cognitively intact with a BIMS score of 15 out of 15. Further review showed s/he required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene, and physical assistance of one staff member for bathing. Review of the current care plan, last revised 1/25/22, showed the resident preferred bathing to occur at least once per week, and required the assistance of 1 person for bathing/showering. The following concerns were identified: a. Interview with the resident on 4/12/22 at 1:43 PM revealed s/he " ...hadn't had a shower in 3 weeks ..." S/he also stated she would like at least 2 showers per week, but the facility " ...can barely get me one." Interview with the resident on 4/14/22 at 2:19 PM revealed s/he was " ... under the impression Sundays are my shower days ..." b. Review of the CNA task documentation for bathing and ADL care for the past 30 days showed the resident was scheduled for Friday showers. Further review showed the resident had 2 documented showers, 3/18/22 and 4/10/22, in the 30-day look back period; it was noted the shower on 3/18/22 was documented as refused.	F 677	response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with the State Operations Manual. 1. Residents #10, #29, #43, and #312 have been assessed for bath preference, care plan updated, and bathing has been provided. 2. Initial audit completed by DNS/Designee to assess current residents for other concerns related to bathing with corrections made as needed. 3. Nursing staff has been educated on shower requirements. Ongoing audits will be completed by DNS/Designee weekly times 3 months to assess for appropriate shower completion. 4. Results of initial and ongoing audits will be reviewed via the QAPI process monthly times three months for further recommendations.	

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F 677	Continued From page 2	F 677		

2. Review of the current physician orders showed resident #312 was admitted to the facility on 3/31/22 with diagnoses that included multiple sclerosis, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cognitive communication deficit, weakness, and need for assistance with personal care. Review of the current care plan, last revised 4/12/22, showed the resident's bathing days were Monday and Friday, and the resident required assistance of staff with bathing/showering, dressing, transfers, and personal hygiene. The following concerns were identified:

a. Observation of the resident on 4/12/22 at 1:43 PM showed the resident in his/her recliner and wearing gray sweatpants and a gray sweatshirt, which were both noted to be visibly dirty, with debris and what appeared to be new, wet stains from spills. His/her hair was unkempt, greasy, had not been combed, and contained pieces of debris and dandruff.

b. Review of CNA task documentation for bathing and ADL care for the past 30 days showed the resident was scheduled for showers on Wednesday and Saturday. Further review only showed a shower documented on 4/9/22, and a bed bath documented on 4/13/22.

c. Interview with LPN #2 on 4/13/22 at 1:42 PM revealed she had given the resident a bed bath early that morning. However, observations of the resident on 4/13/22 at 11:05 AM and 12:05 PM showed the resident wearing the same clothes s/he wore on 4/12/22, and was in the same unkempt condition as previously observed.

d. Interview with the resident on 4/13/22 at 12:05 PM revealed the resident had not had a shower or bed bath that day. S/he stated s/he was hopeful to possibly get one later that afternoon.

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3. Review of the 2/24/22 significant change MDS assessment showed resident #43 had diagnoses that included hemiparesis or hemiplegia. The assessment showed the staff assessed the resident's cognitive status as modified independence for cognitive skills for daily decision making. The resident required extensive assistance with 1 person physical assist for personal hygiene and physical help in part with 1 person physical assist for bathing. Review of the care plan with a revised date of 7/16/21 showed the resident preferred to bathe/shower twice weekly. The following concerns were identified:

a. Review of the bathing records for the last 30 days showed the resident had 4 showers documented (one on 3/18/22, two showers on 3/25/22 and one shower on 3/29/22). There had been no documented baths/showers for 15 days from 3/29/22 to 4/13/22.

4. Review of the 2/28/22 admission MDS assessment showed resident #29 had moderate cognitive impairment with a BIMS score of 12 out of 15 and required supervision and set-up help for personal hygiene, and physical help in part for bathing. Review of the 2/16/22 care plan showed the resident preferred to bathe/shower twice weekly, and as needed. The following concerns were identified:

a. Review of the bathing records for the last 30 days showed the resident had 5 showers documented, and 1 documented refusal from 3/15/22 to 4/13/22. There were no recorded bathes/showers for 13 days from 3/31/22 to 4/13/22.

b. Interview with the resident on 4/14/22 at 10:17 AM revealed the resident was not sure the last time s/he received a shower.

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F 677	Continued From page 4 5. Interview with LPN #1 on 4/14/22 at 9:46 AM revealed showers were to be provided by the CNAs working the halls. She stated the CNAs were responsible to get their assigned residents showered on their shower schedule days. If a resident refused they kept a note to try and get those done another time. 6. Interview with the DON on 4/13/22 at 4:18 PM confirmed the documentation showed there had been concerns regarding showers in the past 2 weeks.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		4/23/22

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F 690	Continued From page 5 (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 medical record review, staff interview, and policy and procedure review, the facility failed to ensure catheter orders and parameters were implemented and followed for 1 of 4 sample residents (#85) reviewed for catheter use and care. The findings were: 1. Review of the 3/17/22 significant change MDS assessment showed resident #85 was re-admitted to the facility on 3/11/22, with diagnoses that included sepsis due to methicillin resistant staphylococcus aureus (MRSA), need for assistance with personal care, urinary tract infection (UTI), and neuromuscular dysfunction of bladder. Further review showed the resident required extensive assistance of one person for toilet use and personal hygiene. The resident also received an antibiotic on 6 of 7 days during the 7-day look-back period. Review of the current care plan, last revised 4/12/22, showed the resident had a problem area initiated on 2/23/22 stating s/he had " ... a colostomy/suprapubic catheter in place" with interventions that included "Cleanse area around ostomy/suprapubic catheter site per MD order/PRN." Further review	F 690	1. Resident #85 orders were assessed and re-written to include directions for interventions, care, assessments and maintenance. Review of nursing charting to ensure resident catheter care took place every shift and PRN. Resident discharged 5/2/22. 2. Initial audit completed by DNS/Designee reviewing residents with urinary catheters with any concerns identified corrected. 3. Nursing staff have been educated on catheter orders and catheter care to be provided by nursing staff every shift and PRN including documentation. Ongoing audits will be completed by DNS/Designee weekly times three months to assess for appropriate orders and documentation related to catheter use. 4. Results of initial and ongoing audits will be reviewed via the QAPI process monthly times three months for further recommendations.	

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F 690	Continued From page 6	F 690		

showed a problem area initiated on 3/11/22 stating s/he was " ... on oral [antibiotics] [related to] UTI." The following concerns were identified:

a. Review of current physician orders showed a 3/16/22 order for "Suprapubic catheter." Further review showed no directions or indications for the order related to interventions, cares, assessments, or maintenance.

b. Review of the CNA task documentation "[Bowel & Bladder] - Catheter Care to be performed every shift and PRN" showed the resident did not have cares documented as performed from 2/10/22 - 2/14/22 (4 days), or from 3/11/22 - 4/11/22 (31 days).

c. Review of nursing progress notes from 3/4/22 showed the resident was sent to the hospital for evaluation due to altered mental status, a rapid new-onset irregular pulse, and a fever of 102.1 degrees Fahrenheit. Further review showed the resident returned to the facility on 3/11/22, with diagnoses of sepsis due to MRSA, as well as a UTI. Review of the March 2022 and April 2022 MARs showed the resident required vancomycin (a powerful antibiotic) intravenously, as well as oral antibiotics cefdinir and levofloxacin, to treat the infections.

2. Interview with the administrator, DON, and regional nurse revealed staff " ... know what to do and how to care for a catheter, and refer to the care plan if not sure." They confirmed the suprapubic catheter order did not specify directions for insertion, removal, maintenance, or assessments of the catheter or the suprapubic catheter site. They further confirmed catheter cares were to be done and documented daily during every shift, stating it was a standard of practice.

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F 690	Continued From page 7 3. Review of "Nursing Interventions and Clinical Skills" by Perry, Potter, and Ostendorf (2020), seventh edition, showed "Urinary Elimination - Suprapubic Catheter Care ... 19.4 ... Evaluation ... 2. Monitor for signs of infection (e.g., fever, elevated white blood count) and observe urine for clarity, sediment, unusual color, or odor ... Suprapubic catheters increase risk for UTI ... 3. Observe catheter insertion site for erythema, edema, discharge, tenderness. Check dressing at minimum of every 8 hours ... Recording - Record condition of insertion site, character of urine, type of dressing change, and patient's comfort level with the catheter and dressing change."	F 690		
F 812 SS=F	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:	F 812		4/23/22

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F 812	Continued From page 8 Based on observation, staff interview, and review of the Food Code, the facility failed to ensure sanitation requirements were met in the facility kitchen and dish room. The census was 112. The findings were: 1. Observation on 4/11/22 at 1:40 PM showed there were cleanliness issues in the kitchen and dish room. The following areas needed cleaning: a. The wall and shelving in the back preparation area were soiled with dried food debris. b. The walk-in-cooler and freezer door handles were visibly soiled with food debris. c. The container for the plastic wrap located on a shelf in the back preparation area was soiled with dried-on food debris. d. The wall near the opening to the dish room was soiled with blackish grease/grime. The door to the office from the kitchen was soiled with blackish grease/grime. e. The ceiling vents above the clean dish area were soiled with dark-colored dust. f. The ceiling vents and tiles above the cooking equipment were soiled and damaged with discoloration and dried water spots. g. The exterior of the cooking equipment including the range, and the ovens had accumulated dried food and grease on the surfaces. h. The toaster located on the front preparation table appeared to be very aged and had worn, flaking material on the top and front surfaces. i. The wall behind the dish machine was splattered and discolored with food debris. j. The floor around the foot pedals to operate the hand washing sink in the kitchen as well as the hand washing sink in the dish room had	F 812	1. Cleanliness issues immediately addressed: a.The wall and shelving in back preparation area cleaned to remove any dried food debris. b.The walk in cooler and freezer door handles cleaned. c.The container for the plastic wrap has been cleaned to remove any dried food debris. d.The wall near dish room and door to office have been cleaned to remove any grime. e.The ceiling vents have been cleaned to remove any dust. f.The ceiling vents and tiles above the cooking equipment have been cleaned and replaced to ensure there is no discoloration or damage. g.The exterior of cooking equipment has been cleaned to ensure clean surfaces. h.The toaster has been replaced. i.The wall behind the dish machine has been cleaned to ensure no food debris. j.The foot pedals have been replaced on the hand washing sinks to ensure hot water works pedal is functional. In addition, the floor around the foot pedals have been cleaned. 2. New cleaning schedule has been implemented to ensure kitchen stays clean. 3. Staff educated on cleanliness in kitchen, cleaning importance and writing maintenance needs in the log on 1st floor. Ongoing audits will be completed by the Executive Director/Designee weekly times three months to assess for compliance. 4. Results of initial and ongoing audits	

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F 812	Continued From page 9 accumulated grime surrounding the devices and the devices were not functioning to turn on the hot water. 2. Interview with the dietary manager on 4/13/22 at 11:33 AM revealed deep cleaning had been done about 1 month prior and more was needed to address these areas. 3. According to Food Code 2017, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 4. According to Food Code 2017, U.S. Public Health Service: 6-501.18 "Handwashing facilities are critical to food protection and must be maintained in operating order at all times so they will be used." 5. According to Food Code 2017, U.S. Public Health Service: 5-202.12 "Warm water is more effective than cold water in removing the fatty soils encountered in kitchens. An adequate flow of warm water will cause soap to lather and aid in flushing soil quickly from the hands. ASTM Standards for testing the efficacy of handwashing formulations specify a water temperature of 40°C ± 2°C (100 to 108°F). An inadequate flow or temperature of water may lead to poor handwashing practices by food employees. A mixing valve or combination faucet is needed to provide properly tempered water for handwashing. Steam mixing valves are not	F 812	will be reviewed via the QAPI process monthly times three months for further recommendations.	

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F 812	Continued From page 10 allowed for this use because they are hard to control and injury by scalding is a possible hazard."	F 812		
F 880 SS=E	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		4/23/22

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F 880	Continued From page 11 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, staff interview, and policy and procedure review, the facility failed to ensure infection control practices were implemented during 7 random observations. The census was 112. The findings were:	F 880	1. DON, IP and applicable IDT members conducted root cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure face masks and face shields worn appropriately.	

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 04/14/2022

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 880	Continued From page 12 1. The following concerns were identified related to resident care equipment: a. Observation on 4/11/22 at 2:10 PM showed a mechanical sit-to-stand lift outside of room 206 was visibly dirty with dried substances that had dripped on top of and to the interior of the knee pad areas. Further observation showed the foot platform contained a large amount of dirt and debris. b. Observation on 4/11/22 at 2:13 PM showed two mechanical sit-to-stand lifts outside of room 221, both with visibly dirty knee pad areas, as well as dirt and debris on the foot platform. Further observation showed one lift had a blue padded cover that was visibly stained and dirty. c. Observation on 4/11/22 at 2:52 PM showed a mechanical sit-to-stand lift outside of room 109, with the foot platform visibly dirty with debris. d. Observation on 4/12/22 at 1:11 PM showed a mechanical lift outside of room 206, and another outside of room 215. Both had visibly dirty foot platforms, containing dirt and debris. e. Observation on 4/13/22 at 4:39 PM showed a mechanical lift outside of room 216, with a foot platform that was visibly dirty with debris. f. Interview with CNA #1 on 4/11/22 at 4:43 PM revealed they were supposed to clean the lifts between each resident. 2. The following concerns were identified related to mask use: a. Observation on 4/11/22 at 3:23 PM showed RN #1 sitting at the nurses station in the resident common area with his mask on his ears but under his chin, not covering his mouth or nasal passages. b. Observation on 4/11/22 at 3:29 PM showed RN #1 walking down the hall and sitting down at	F 880	DON, IP and applicable IDT members conducted root-cause analysis to identify and address the reasons for non-compliance related to a. Failure to ensure dedicated resident-care equipment (mechanical lifts) was used or if not available then the equipment was cleaning and disinfecting according to manufacturers instructions using an EPA-registered disinfection prior to use on another resident or when soiled. 2. The DON and IP educated the following: a. All staff educated on the proper use of PPE in accordance with current CDC and CMS guidelines. b. All staff are educated on the use of dedicated or disposable noncritical resident care equipment, if available, or the procedures for disinfecting the equipment between residents in accordance with the current CDC and CMS guidelines. c. All staff are educated on the appropriate cleaning procedures and approved disinfectants. 3. Facility leadership contacted the Mountain Pacific Quality Improvement Organization 4/28/22 to inquire about the assistance of services available from the QIP in improving infection prevention and control in the facility. 4. Monitoring of approaches to ensure infection control and prevention are effective will include: a. Weekly for no less than 12 weeks, the IP, DON and applicable IDT will conduct ongoing monitoring via observation to ensure staff are complying with	

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F 880	Continued From page 13 the nurse's station in the resident common area with his mask on his ears but under his chin. c. Observation on 4/11/22 at 5:32 PM showed RN #2 wearing her mask below her nasal passages. 3. Interview with the administrator on 4/14/22 at 3:22 PM revealed it was the facility's expectation for the face mask to be worn over the mouth and the nose. In addition, she revealed the expectation was for the mechanical lifts to be cleaned between residents, and when visibly dirty. Review of facility policy "Standard Precautions," last revised May 2015, showed "Standard precautions include the following practices: ... 3. Masks, Eye Protection, Face Shields ... a. Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and resident care activities ... 5. Resident-Care Equipment... a. Handle used resident-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that protects skin and mucous membrane exposures, contamination of clothing, and transfer of other microorganisms to other residents and environments ... b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed ..."	F 880	requirements for: i. Compliance of staff with the use of face mask and shields. ii. Compliance of staff with the proper use or disinfecting of noncritical resident care equipment. iii. Compliance of staff with the appropriate procedures and disinfecting products for environmental cleaning. Audits will be conducted weekly x12 weeks and then monthly x3. Audits and monitoring will be brought to QAPI. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the QAPI committee and medical director.	