

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments	E 000			
K 000	An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 04/12/2022. Based on the findings it was determined the facility was in compliance with all requirements. INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 04/12/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.70(a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, three story building with a basement of a Type II (222), and Type II (111) construction built in 1966 and 1972. The building was equipped with a supervised automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 146 certified Medicare and Medicaid beds with a census of 113 residents.	K 000			
K 100 SS=E	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 100		4/22/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/06/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 100	Continued From page 1 Based on observation and staff interview, the facility failed to maintain ceiling systems in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain ceiling systems as required could result in injury or death due to a delayed response from fire suppression and alarm systems. The deficiency affected two (2) of numerous rooms. The findings were: Observation on 4/12/2022 at 9:00 AM in the 2nd floor back dining closest found a ceiling tile partially missing adjacent to a fire sprinkler. Further observation at the kitchen's back exit corridor revealed a hole in the ceiling adjacent to a smoke detector. In both situations, heat and smoke could bypass the fire protection systems resulting in a delayed response by the sprinkler or fire alarm system. Interview with the facility maintenance staff and regional manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.1.1.1.3, 4.6.12.1	K 100	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. 1. The ceiling tile on the 2nd floor back dining has been replaced on 4/13/22. The hole in the ceiling adjacent to the fire sprinkler has been repaired 4/13/22. 2. Facility conducted full audit to ensure no other ceiling tiles are missing and/or need to be replaced. 3. Maintenance staff educated on importance of ceiling tiles and ensuring all holes in walls are repaired. 4. Maintenance director or designee will audit ceiling tiles x3 months to ensure ceiling tiles are present and in proper condition. Audit will be brought to QAPI.		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless	K 222		4/22/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 222	Continued From page 2 using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 222	Continued From page 3 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous exits throughout the facility. Observation on 04/12/2022 at 8:44 AM at the 3rd floor secured unit stairwell door revealed that the delayed egress was not provided with signage reading "PUSH UNTIL ALARM SOUNDS - DOOR CAN BE OPENED IN 15 SECONDS" as required by the Life Safety Code. Interview with the facility maintenance staff and regional manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time	K 222	1. Third Floor secured unit stairwell door signage was provided reading PUSH UNTIL ALARM SOUNDS ☐ DOOR CAN BE OPENED IN 15 SECONDS, on 4/12/22. South Basement Stairwell exit door has been repaired to open with correct amount of force on 4/13/22. 2. Facility conducted full audit of egress doors to ensure all opened in the correct amount of time with the correct amount of force, and had correct signage. 3. Maintenance staff educated on 15 second egress time as well as not using excessive force to exit through door. In addition, Maintenance staff educated to ensure correct signage is on the door. 4. Maintenance director or designee will audit egress doors monthly x3. Audit will be brought to QAPI		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 222	Continued From page 4 of exit acknowledged the deficiency. Ref. 2012 NFPA 101: Section 19.2.2.2.4(2); 7.2.1.6.1.1 (4) 2. Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous exits throughout the facility. The findings were: Observation on 04/12/2022 at 11:12 AM at the south basement stairwell exit door revealed that the door required a force in excess of 15 lbf to start the irreversible process to release the lock. Interview with the maintenance manager and administrator at the time of the observation acknowledged the excessive force, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref. 2012 NFPA 101: Section 19.2.2.2.4(2); 7.2.1.6.1.1(3)(a)	K 222			
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		4/22/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 225	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwells free of combustible materials in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of four (4) stairwells in the facility. Observation on 04/12/2022 at 8:09 AM in the north stairwell revealed combustibles stored on the third floor landing. Interview with the facility maintenance staff and regional manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref. 2012 NFPA 101: Section 19.2.2.3; 7.2.2.5.1.1; 7.1.3.2.3	K 225	1. Combustible material removed from third floor stairwell landing on 4/12/22. 2. Facility conducted full audit of the four stairwells to ensure no materials were stored in there. 3. Maintenance staff educated on importance of nothing stored in stairwells. 4. Maintenance director or designee will audit stairwells monthly x3. Audits will be brought to QAPI.		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321		4/22/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 321	Continued From page 6 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 1010, Life Safety Code. Failure to maintain hazardous areas as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 04/12/2022 at 9:42 AM in the activities office revealed the office was being used to store a large amount of combustible activities supplies. The office was sprinklered but the doors were not provided with a self- or automatic-closing device. Interview with the facility maintenance staff and	K 321	1. A self-closure device was added to the activity's office 4/12/22. 2. Facility conducted full audit of offices to ensure no other self-closures were needed. 3. Maintenance staff educated on importance of self-closure door when large amount of combustible supplies are being stored. 4. Maintenance director or designee will audit offices monthly x3 to ensure no other self-closures are needed. Audits will be brought to QAPI.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 321	Continued From page 7 regional manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 321			
K 351 SS=E	Ref: 2012 NFPA 101 Section 19.3.2 Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could	K 351	1. Sprinkler escutcheons missing in the back-dining room on 2nd floor, and in the DON office. Both sprinkler escutcheon replaced on 4/13/22. 2. Facility conducted full audit of Sprinkler escutcheons to ensure none	4/22/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 351	Continued From page 8 result in injury or death in the event of a fire. The deficiency affected two (2) of numerous sprinkler heads throughout the facility. The findings were: Observation on 04/12/2022 at 9:00 am in the back dining on the 2nd floor above the serving area, revealed a fire sprinkler head with the escutcheon missing, exposing the annular space above. An additional observation at the 2nd floor director of nursing office revealed a fire sprinkler head with the escutcheon missing, exposing the annular space above. Interview with the facility maintenance staff and the regional manager at the time of each observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.3.5.1, 9.7.1.1(1) 2010 NFPA 13: Section 6.2.7.1	K 351	others needed to be replaced. 3. Maintenance staff educated on importance of sprinkler escutcheons and risk of exposing annular space above. 4. Maintenance director or designee will audit sprinkler escutcheons monthly x3 to ensure no other escutcheons need to be replaced. Audit to be brought to QAPI.		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test	K 353		4/22/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 353	Continued From page 9 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain sprinkler piping hangers in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler piping hangers as required could result in improper operation or failure during a fire emergency. The deficiency affected one (1) of numerous sprinkler heads throughout the facility. The findings were: Observation on 04/12/2022 at 8:21 AM at the 3rd floor north corridor outside the bathing room revealed a sprinkler head that was not in its' proper location. Further review revealed that the sprinkler head was floating within the ceiling plane, and not properly supported due to a loose or broken pipe hanger. Interview with facility maintenance staff and the regional manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 19.3.5.1, 9.7.5 2011 NFPA 25, Section 5.2.3.2	K 353	1. Sprinkler observed on 3rd floor north corridor outside of bathroom has been corrected to be in its proper location, pipe hanger adjusted on 4/13/22. Items in medical records and central supply were stacked within 18 inches of the ceiling have been removed to ensure nothing is stored within 18 inches. 2. Facility conducted full audit of items stored too close to the ceiling. 3. Maintenance staff and all staff within an office educated on importance of items not being closer than 18 inches to the ceiling. 4. Maintenance director or designee will audit storage being placed too close to the ceiling monthly x3 to ensure proper storage procedure. Audit to be brought to QAPI.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 353	Continued From page 10 2. Based on observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected two (2) of numerous rooms throughout the facility. The findings were: Observation on 04/12/2022 at 11:12 AM in the medical records storage room revealed that were stacked to within several inches of the sprinkler heads. Further observation at the basement central storage area revealed stored materials stacked to within 18 inches of the sprinkler heads. Interview with facility maintenance staff and the regional manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2	K 353			
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	K 511			4/22/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 511	Continued From page 11 installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in misidentification of electrical circuits and inhabit appropriate service or maintenance. The deficiency affected one (1) of numerous panelboards in the facility. The findings were: Observation on 04/12/2022 at 8:20 AM at the 3rd floor pantry in the large panelboard revealed that a circuit directory was missing from the inside or face of the panel door. Interview with the facility maintenance staff at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Sections: 408.4(A) 2. Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety	K 511	1. 3rd floor pantry circuit directory replaced in panel door 4/13/22. Junction box without cover next to refrigerator light has been replaced 4/13/22. 2. Facility conducted full audit of all circuit directories to ensure all doors have a directory, as well as junction box covered. 3. Maintenance staff educated on importance of circuit directory on all circuit panel doors, as well as junction box covers. 4. Maintenance director or designee will audit all circuit directors and junction box covers monthly x3 to ensure they are all listed. Audit to be brought to QAPI.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 511	Continued From page 12 Code, and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in injury or death due to exposed electrical devices or wiring. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 04/12/2022 at 9:51 AM in the walk-in refrigerator revealed a junction box without a cover next to the refrigerator light. Interview with facility maintenance staff and the regional manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 314.28(3)(C)	K 511			
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 761			4/22/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER GRANITE REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 761	Continued From page 13 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain fire doors as required could result in injury or death during an emergency. The deficiency affected eight (8) fire door assemblies out of many throughout the facility. The findings were: Observation on 04/12/2022 starting at 8:10 AM of the fire door at the north 3rd floor stairwell revealed that the frame was missing the listing tag. It was also observed that the door itself had its tag covered in paint which prevented observation of the rating. Additional observation of the fire door assemblies at the oxygen rooms, as well as the stairwell doors located at the end of the 2nd and 3rd floor corridors, revealed the UL tags to be missing, painted, or otherwise made illegible. Interview with facility maintenance staff and the regional manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.5, 7.2.4.3.1, 8.3.3.1, 8.3.3.2, 8.3.3.2.2	K 761	1. At this time, we have requested a time limited waiver for 90 days. 2. Facility conducted full audit of all door and frame tags throughout facility to ensure no other tags were missing and needed to be replaced. 3. Maintenance staff educated on importance of door tags and frame tags. 4. Maintenance director or designee will audit all door and frame tags monthly x3 to ensure they are legible and intact. At this time requesting a time limited waiver for 90 days.		