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 11/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 11/22/22 to 11/23/22. The survey was prompted by complaint intakes WY00003492 and WY00003497.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident, guardian and staff interview, facility-reported incident review, and policy and procedure review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (#2) reviewed for resident-to-resident altercations. This failure resulted in harm to resident #2 who experienced sexual abuse a reasonable person would have found humiliating, intimidating, demeaning, and degrading. The findings were: Review of the 10/28/22 quarterly minimum data	F 600	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	11/25/22

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

Electronically Signed | 12/16/2022

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F 600	Continued From page 1 set (MDS) assessment showed resident #2 had a brief interview for mental status (BIMS) score of 9 of 15, indicating moderate cognitive impairment. Further review showed the resident had diagnoses which included multiple sclerosis and non-Alzheimer's dementia. Observation and an unsuccessful interview with the resident on 11/23/22 at 11 AM showed the resident in his/her room in a wheelchair in no distress. At that time an interview was attempted, and the resident appeared confused and could only respond to questions in the moment that included, "How are you today?" The resident was unable recall the past. Review of the 8/29/22 annual MDS assessment showed resident #1 had a BIMS score of 15 of 15, indicating intact cognition. Further review showed the resident had diagnoses which included other symptoms and signs involving cognitive functions and awareness, anxiety disorder, unspecified impulse disorder, dysthymic disorder, and mild cognitive impairment of uncertain or unknown etiology. Observation and interview with the resident on 11/23/22 at 11:05 AM showed the resident sitting on the side of his/her bed in no distress, and at that time s/he could answer simple questions appropriately, though s/he denied ever having any negative contact with residents or staff. Review of the resident's care plan showed the following plan initiated 4/6/21 and revised on 10/31/22: "[Resident's name] has times of being sexually inappropriate. [Resident name] has a history of exhibiting sexual attraction/feelings towards minors. A revision on 10/31/22 showed the resident had touched another resident in an unwanted sexual manner, and interventions that included supervision when the resident was near	F 600	constitutes the facility□s allegation of compliance in accordance with the State Operations Manual. Request for IDR at this time. 1. Resident #2 feels safe and comfortable residing at Granite Rehabilitation and Wellness Center per verbal interviews and is not presenting with any negative feelings or emotions related to the unwanted touching incident.Resident #1 relocated to a different floor, care plan updated to address inappropriate touching, medication review and resident continues to deny allegation. 2. Initial audit completed by IDT to assess for other residents who may be at risk for inappropriate touching/abuse. 3. Education provided to current staff related to abuse and abuse reporting by Executive Director on 11/1/22 and 11/25/22. Ongoing audits will be completed for 10 residents per week times three months to assess for concerns related to inappropriate touching/abuse. Potential admits will be screened for potential risk for inappropriate touching/abuse concerns. Resident #1 resides on a unit with alert and oriented residents across from the nurse’s station with increased supervision. Resident #1 educated regarding the possible risks/consequences of sexually inappropriate behavior towards others and DD Waiver is pending for placement in a more suitable environment. Resident #1 remains on outpatient psych services and	

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F 600	Continued From page 2 other residents in order to ensure the resident was not close enough to touch other residents were included. An additional care plan initiated 1/14/21 and revised 6/7/22 showed the resident's inappropriate sexual behavior did not include other individuals. The issues identified were: Bold sexual behaviors, fondling, masturbation, and self flogging. The following concerns were identified: 1. Review of a facility incident reported to the state survey agency on 10/31/22 showed an incident between residents #1 and #2 occurred on 10/30/22. The review showed resident #1 had allegedly touched resident #2 in an unwanted manner on the leg and in the groin area. 2. Interview with certified nurse aide (CNA) #2 on 11/23/22 at 10:40 AM revealed she witnessed resident #1 touch the leg of resident #2, then grab resident #2 in the groin. She then stated resident #2 was saying "no" and pushing resident #1 away with his/her hand. CNA #2 stated there were no other witnesses to this incident. She stated she removed resident #2 to safety in his/her room and reported the incident to the charge nurse. Interview with licensed practical nurse #1 on 11/23/22 at 10:30 AM revealed she did not witness the incident on 10/30/22 between resident #1 and resident #2. She was told by a CNA that the incident occurred, and she reported it at that time to supervision. 3. Review of the progress notes for resident #2 showed the following notes: a. "10/30/22 at 20:29 [8:29 PM]: Resident was in the dining room when another resident placed [his/her] hand on [his/her] lap, grabbing [his/her] groin area. Resident was very upset, yelling at [him/her]. Residents separated, this	F 600	has been referred for counseling services. 4. Results of audits will be reviewed via the QAPI process monthly times at least three months for further recommendations.	

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F 600	Continued From page 3	F 600		

resident was taken to [his/her] room and comforted. ADON [assistant director of nursing] and DON [director of nursing] notified."

b. "11/2/22 at 23:32 [11:32 PM]: Observation continues r/t [related to] previous episode of unwanted touching from another res [resident]. The other res [resident #1] was observed after supper to come into the dining room and go over to table where this res [resident #2] was sitting with [his/her] tablemate's playing cards. [Resident #2] sat up very stiff with shoulders squared and stopped talking. This nurse instructed the other res to leave the area and come back over to the nurse's station, then went back to check on this res. [Resident #2] thanked this nurse for intervening, stating 'I don't want [him/her] around me'. Res reassured [s/he] is being watched and we will keep [him/her] away. Later in the evening [resident #2] was observed self-propelling w/c [wheelchair] past nurse's station to try and head to [his/her] room. [Resident #1] was at the station at the time near the phone. As [resident #2] approached the nurse's station res made contact with this nurse. I helped res go quickly past the station keeping wide berth of space between the two residents, and took [the resident] to [his/her] room. Upon arriving at the room res again thanked this nurse, stating [s/he] didn't want [him/her] to talk to [him/her]. When I asked res questions regarding how [s/he] is feeling, [s/he] stated [s/he] does not feel afraid of [him/her], only angry at [him/her], and wants to be left alone. Stated [s/he] forgets about it until [s/he] sees [him/her] and then remembers. Also stated [s/he] feels a bit like nobody believes [him/her]. Res reassured that I have known [him/her] for almost 15 years now and I know [s/he] would never make an accusation like that which was untrue and that we do believe [him/her], and that [s/he] is

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F 600	Continued From page 4	F 600		

not alone in feeling this way. Encouraged to keep talking and let us know how [s/he] is doing, even if [s/he] just needs to be angry or cuss about it. Res became a bit tearful and thanked this nurse and gave me a hug. Res states [s/he] hopes [s/he] will forget about it again."

4. Review of the care plan for resident #2 showed a plan initiated on 10/31/22 and revised on 11/22/22 to address the following: "Problem: [Resident's name] is at risk for feelings of trauma or re-traumatization due to past trauma [s/he] has experienced that includes sexual abuse." The plan included goals and interventions to address sexual abuse.

5. Interview with the guardian of resident #1 on 11/23/22 at 10:20 AM revealed the facility notified her of the 10/30/22 sexual abuse allegation against resident #1 which involved resident #2. She further stated she had never heard an allegation of sexual misconduct between resident #1 and anyone else until that allegation.

6. Interview with the administrator on 11/23/22 at 3:45 PM revealed the facility took the sexual abuse allegation of 10/30/22 between resident #1 and resident #2 seriously, protected resident #2 by making staff aware, reported to the state, and resident #1 was relocated to the first floor for additional oversight, as s/he continued to approach resident #2.

7. Review of the policy titled, "Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation" published December 2003 and updated October 2022, showed a Policy

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F 600	Continued From page 5 Statement as follows, "Each resident has the right to be free from abuse including ...sexual..." Further review showed sexual abuse included any non-consensual sexual contact of any type with a resident. Review of the Procedure showed, "...3. Prevention: The Center implements written policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation."	F 600		