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 05/25/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 5/22/23 to 5/25/23. Also reviewed in the course of the survey were complaint intakes WY00003513, WY00003527, WY00003531, WY00003563, WY00003570, WY00003578, WY00003580, WY00003587, and WY00003595. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living BIMS: Brief Interview for Mental Status CDM: Certified Dietary Manager CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse	F 000		
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	F 690		6/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2023

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.

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 05/25/2023

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 690	Continued From page 1 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to provide timely assistance with toileting care for 1 of 7 residents (#48) reviewed for ADLs. The findings were: 1. Review of the 5/10/23 quarterly MDS assessment showed resident #48 had severely impaired cognition and required the extensive assistance of 2 staff members for toileting, transfers, and personal hygiene. The resident was frequently incontinent of bowel and bladder and, according to the assessment, no toileting program had been attempted during the resident's stay at the facility. Further, the resident had a diagnosis of dementia. Review of the resident's care plan for ADL self-care	F 690	Reparation 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 s 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.	

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 05/25/2023

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 690	Continued From page 2 performance deficit related to toilet use and last revised on 7/9/20 showed "[Resident] requires assist with toilet use." The following concerns were identified: a. Continuous observation on 5/22/23 from 11:51 AM to 1:50 PM showed the resident was at a table in the common room sitting in a wheelchair. The resident stated s/he needed to use the bathroom several times to staff, was restless, and appeared agitated. Staff acknowledged the resident's request for toileting; however; failed to provide toileting assistance. b. Continuous observation on 5/23/23 from 8:30 AM to 11:55 AM showed the resident was lying in bed on his/her left side with a wedge behind his/her back. At no time was the resident checked for incontinence, repositioned, or offered toileting. c. Observation on 5/23/23 at 11:55 AM with CNA #2 showed the resident had been incontinent of urine with the bed sheets, the resident's clothing, and the resident's skin visibly wet. The resident complained at this time that s/he "...was all wet." The CNA indicated "everything was wet" and she thought the resident was last changed about 9:30 AM. d. Interview with CNA #1 on 5/23/23 at 12:10 PM revealed the resident was last changed at 6 AM. 2. Interview with the DON and NHA on 5/25/23 at 3:15 PM revealed it was the facility's expectation staff were to provide toileting and incontinence care frequently and per the residents' care plans.	F 690	F690 CORRECTIVE ACTION Resident #48 was toileted at 12:10 on 5/23/2023. CNA #1 and CNA #2 provided with 1:1 education on 5/25/23. The Nursing staff to be educated by 6/19/2023 regarding appropriate frequency of toileting and incontinence care. IDENTIFICATION OF OTHERS Residents residing at facility who have incontinence are at risk. Audit was completed on 6/5/23 to identify residents who have urinary/fecal incontinence by DNS. SYSTEMIC CHANGE Nursing staff being provided in-service education by the DNS/designee to be completed by 6/19/2023 on appropriate frequency of incontinence care. The DNS/designees audits toileting frequency through observation of care on 10 random residents who require incontinence care to validate timely completion of care. MONITORING The Director of Nursing Services brings the results of the of the Incontinence Care Monitoring records to the Quality	

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 05/25/2023

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 690	Continued From page 3	F 690	Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue 5 times a week for 4 weeks, 3 times per week for 4 weeks and then 1 time per week for 4 weeks. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		6/23/23

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 05/25/2023

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 758	Continued From page 4 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medication-specific target behaviors and appropriate monitoring were in place for 1 of 5 (#43) sample residents reviewed for psychotropic medication use. The findings were: 1. Review of the 3/29/23 significant change MDS assessment showed resident #43 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included dementia, anxiety disorder, and depression. Further review showed the resident received an antipsychotic and an antidepressant 7 days of the 7-day look-back period. Review of physician orders showed the resident was prescribed Abilify (an antipsychotic) 5 milligrams	F 758	F 758 CORRECTIVE ACTION Medication specific target symptom monitoring put in place for resident #43 for Abilify and Depakote on 5/26/23. IDENTIFICATION OF OTHERS Facility wide audit was completed on residents receiving Psychotropic drugs on 5/31/2023 by the DNS/designee to validate medication specific target behaviors and appropriate monitoring were in place. Residents who did not have monitoring in place were corrected	

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 05/25/2023

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 758	Continued From page 5 (mg) by mouth daily related to generalized anxiety disorder and delusions; Depakote (an anticonvulsant) 375 mg by mouth one time a day related to major depressive disorder; and venlafaxine (an antidepressant) 75 mg by mouth one time a day related to major depressive disorder. The following concerns were identified: a. Review of the resident's psychotropic medication care plan related to depression, last revised 3/17/22, showed to "monitor/record occurrence of for target behavior symptoms (EX: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression toward staff/others. etc.) and document per facility protocol)." Interventions included to "administer medications as ordered." Further review showed no medication-specific target symptoms were identified for each medication used. b. Review of the treatment administration record for April 2023 and May 2023 showed the facility had monitoring in place for behaviors and non-pharmacological interventions; however, there were no medication-specific target symptoms identified. 2. Interview with the DON on 5/25/23 at 2:54 PM confirmed medication-specific target behaviors had not been developed for each medication used to treat the resident's anxiety and depression.	F 758	on 5/31/2023. SYSTEMIC CHANGE In-service education was provided to IDT on 5/31/23 on initiation of medication specific target behaviors and appropriate monitoring are in place for new admissions and current residents starting new medications. DNS/designee reviews new admissions to validate behavior medication specific target behaviors and appropriate monitoring are initiated. IDT reviews new admissions at the following business day ensure completion. Medication specific target behaviors and appropriate monitoring is reviewed on residents at the psychotropic meetings to validate monitoring remains in place. DNS/Designee identifies new psychotropic drug orders and validates medication specific target behaviors and appropriate monitoring are put in place. IDT reviews new psychotropic drugs the following business day to validate completion of medication specific target behaviors and appropriate monitoring MONITORING The Director of Nursing Services brings the results of the of the Target Behavior Monitoring records to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue 5	

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 05/25/2023

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 758	Continued From page 6	F 758	times a week for 4 weeks, 3 times per week for 4 weeks and then 1 time per week for 4 weeks. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to ensure residents received additional portions of food according to their personal preferences for 2 of 3 (#36, #287) sample residents reviewed for satisfaction with food services. The census was 82. The findings were: 1. Observation on 5/22/23 at 12:20 PM showed resident #36 was in the dining room for the noon meal. At 12:41 PM the resident requested an additional portion of tomatoes and was told by a staff member that the food had already been taken back to the kitchen. The staff member offered the resident a sandwich instead. Interview with the resident on 5/22/23 at 5:25 PM revealed s/he "had to be okay" with receiving a sandwich; however, s/he would have preferred to have more tomatoes. 2. Interview on 5/23/23 at 10:14 AM with resident	F 800	F 800 CORRECTIVE ACTION Residents # 36 and #287 were offered additional servings at meals on 6/15/23. IDENTIFICATION OF OTHERS Residents who would like to have a second portion of food at a meal have the potential to be affected by this practice. SYSTEMIC CHANGE In-service education was provided to staff on 5/31/23 and instructed to offer a second portion of the meal to residents at meal time. The Dietary staff was provided in-service	6/23/23

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 05/25/2023

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 800	Continued From page 7 #287 revealed the facility did not have enough of the food that was served. The resident stated s/he had requested additional pancakes during the morning meal and was told they were not available. In addition, during the previous evening meal s/he had requested more meatballs and was given a sandwich which s/he did not want. 3. Interview on 5/23/23 at 9:18 AM with the CDM and the dietary manager revealed the facility did not "skimp" on food and the CNAs just needed to call the kitchen if a resident requested an additional portion. In addition, the CDM and the dietary manager thought perhaps the food should be kept on the steam tables until the residents had a chance to request an additional portion, if desired.	F 800	education on 6/15/23 by the dietary manager/designee instructing the serving staff to offer additional food prior to breaking down the steam table at every meal. The assigned meal monitor validates residents are offered a second helping of the meal through observation and interviews. MONITORING The Executive Director brings the results of the of the Meal Monitoring records to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue 5 times a week for 2 weeks, 3 times per week for 8 weeks and then 1 time per week for 2 weeks. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
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	F 812		6/23/23

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 05/25/2023

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 812	Continued From page 8 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 review of the dishwasher temperature log sheet, policy and procedure, and the 2017 U.S. Public Health Service Food Code, and staff interview, the facility failed to ensure the water temperature of the dishwasher was at the proper temperature and/or the sanitizer concentration was checked for 11 of 69 meals. The census was 82. The findings were: 1. Review of the dishwasher temperature log sheet showed the temperature of the wash and rinse water, and the concentration of the chemical sanitizer was to be checked with each meal. The following concerns were identified: a. Review of the May 2023 dishwasher temperature log sheet showed no water temperature or sanitizer concentration was recorded for the evening meals on 5/17, 5/18, and 5/19. b. Review of the May 2023 dishwasher temperature log sheet showed on 5/20 and 5/21 the facility failed to ensure the chemical sanitizer was at the proper concentration for the evening meal. c. Review of the May 2023 dishwasher temperature log sheet showed no water temperature was recorded for the morning and noon meals on 5/21. d. Review of the May 2023 dishwasher	F 812	F 812 CORRECTIVE ACTION Dish machine temperatures and sanitizer concentrations were recorded on 6/1/23. IDENTIFICATION OF OTHERS Residents have the potential to be affected by this practice as there is only 1 dish machine in the center. SYSTEMIC CHANGE In-service education was provided to the dietary staff by the Dietary Manager/designee on 6/15/23 as to recording the Dish machine temperatures and sanitizer concentration 3 times per day every day, and were informed as to what the acceptable parameters for temperatures for a low temp machine are, what the appropriate sanitizer concentration is and what to do if the machine is outside the required parameters. The Dietary Manager/designee verifies	

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 05/25/2023

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 812	Continued From page 9 temperature log sheet showed no water temperature or sanitizer concentration was recorded for the noon or evening meals on 5/22 and 5/23. 2. Interview with the dietary manager on 5/24/23 at 9:40 AM confirmed the temperature of the water and/or the concentration of the sanitizer had not been documented on the log sheets as required. 3. Review of the "Dishwashing" policy, last revised 10/2/20, showed "1. Before washing dishes and utensils from each meal, water temperatures are checked and documented. For low temperature machines also check and document sanitizer levels per meal in parts per million (PPM)..." The temperature of the wash and rinse water must be maintained at a minimum of 120 degrees Fahrenheit and the chemical sanitizer level must be equal to 100 PPM. 4. Review of the 2017 U.S. Public Health Service Code showed "4-302.14 Sanitizing Solutions, Testing Devices. Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons: 1. The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitization; and 2. Too much sanitizer in the final rinse water could be toxic."	F 812	that the temperatures have been recorded on the dish machine 3 times per day and documents findings. If it is identified that a temperature or sanitizer concentration has not been recorded the Dietary Manager re-educates the staff member regarding the requirements. MONITORING The Dietary Manager brings the results of the of the dish machine temperatures/sanitizer concentration audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue 5 times a week for 4 weeks, 3 times per week for 8 weeks. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
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	F 880		6/23/23

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 05/25/2023

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 880	Continued From page 10 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 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	F 880		

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 05/25/2023

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 880	Continued From page 11 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, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection control measures were implemented for 1 observation of resident wound care (#73), and 3 random observations related to personal hygiene and incontinence care which affected residents #8, #13, #26, and #48. The findings were: 1. Review of physician orders for resident #73 showed the resident had a stage 4 pressure ulcer on his/her left gluteal fold with orders to cleanse the wound with wound cleanser; pat dry; soak a strip of gauze with betadine; loosely pack the wound with the betadine-soaked gauze; and	F 880	F 880 CORRECTIVE ACTION LPN #1 was provided education on 5/25/23 on utilizing appropriate infection control technique while providing wound care by the DNS. C.N.A. #2 was educated by the DNS on 5/25/23 regarding infection control technique while providing incontinence care, donning and doffing glove and handwashing.	

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 05/25/2023

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 880	Continued From page 12 cover with an absorbent dressing. Wound care was to be performed daily and as needed. The following concerns were identified: a. Observation on 5/25/23 at 9:32 AM showed LPN #1 was in the resident's room preparing to change the pressure ulcer dressing. The resident was lying on his/her left side with help from CNAs. LPN #1 brought the dressing change supplies into the room and placed them on the dresser by the resident's bed. Plastic cups were used to contain the pre-moistened dressings and packing material. LPN #1 donned gloves and proceeded to remove the soiled dressing from the area as well as the packing material from the wound, and placed the old dressing on an incontinence pad on the resident's bed. LPN #1 attempted to spray the area with the wound cleanser; however, the fluid did not spray and she placed the bottle on the bed. At that time the resident began passing stool and LPN #1 stopped the dressing change and had the CNA provide incontinence care. Once the CNA finished, LPN #1 picked up the cleanser bottle, sprayed the skin and cleansed the area. No gloves were changed or hand hygiene performed after cleansing the wound. LPN #1 then, while still wearing the gloves donned prior to removing the old dressing and cleansing the wound, picked up the pre-moistened gauze and a swab and packed the wound. A dressing of clear film and gauze was then applied to the skin, covering the open area. b. Interview with LPN #1 on 5/25/23 at 10:56 AM revealed the facility's expectations for a clean dressing change was to "prepare the dressing materials, perform hand hygiene, cleanse the wound, change gloves if needed, apply the new dressing, and perform hand hygiene. c. Interview with the infection control nurse	F 880	Incontinence wipes belonging to resident #48 and resident #13 were removed to prevent further cross contamination and replaced with new wipes on 5/25/23. Facility residents were provided new packages of wipe on 5/27/23. C.N.A. #1 and C.N.A. #2 were educated by the DNS regarding using individualized personal item for only the designated resident on 5/25/23. Resident #26 provided with personal hair brush on 5/25/23. On 5/27/2023 resident hair personal items were thrown away and replaced to ensure each resident has their own personal items which are labeled with their initials. IDENTIFICATION OF OTHERS Residents have the potential to be at risk related to this incontinence care, donning and doffing glove and hand washing practice. Residents requiring wound care have the potential to be at risk related to this wound care practice. Residents have the potential to be at risk related to the practice of sharing personal items. SYSTEMIC CHANGE In-service education was provided to 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 05/25/2023

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 880	Continued From page 13 on 5/25/23 at 1:56 PM revealed it was the facility's expectation the procedure for a clean dressing change be adhered to at all times. d. Review of the facility's licensed nurse competency dressing technique aseptic competency dated July 2014 showed "...wash hands and apply gloves ... remove soiled dressing and dispose in plastic bag with gloves...wash hands if visible soiled or use gel hand sanitizer...open supplies ...apply new gloves..." 2. Observation on 5/22/23 at 1:14 PM showed CNA #2 retrieved a brush from a drawer in the common area. CNA #2 brushed the hair of resident #8 and without disinfecting the brush returned it to the drawer. Observation on 5/23/23 at 8:30 AM showed CNA #1 retrieved a brush from the same drawer in the common room and used it to brush the hair of resident #26. Observation of the drawer showed the brush was placed next to a comb and an electric razor with visible hair particles on the brush and the razor. 3. Observation on 5/23/23 at 11:55 AM showed CNA #2 was performing incontinence care for resident #48. CNA #2 removed one wipe from the container and cleaned the resident's perineal area while touching the resident's inner thigh and labia with her gloved hand, used the wipe to cleanse the area, and threw the wipe in the trash. CNA #2 then placed her contaminated gloved hand inside the wipes container and pulled out another wipe and proceeded to provide peri care. After completing the frontal peri care CNA #2 retrieved a clean brief and put it under the resident, still wearing the contaminated gloves. CNA #2 did not provide incontinence care to the buttocks, which were wet with urine. Without	F 880	nursing staff on 5/31/23 by the DNS/designee as to correct infection control technique in relation to incontinence care, gloving, handwashing, wound care and not sharing personal care items. Handwashing education included return demonstration of proper handwashing technique. The DNS/designee conducts wound care infection control audits validating appropriate hand hygiene/donning and doffing of gloves/ barriers between clean and dirty are in place to be completed with five random residents 5 times per week for 4 weeks, 3 times per week for 4 weeks and 1 time per week for 4 weeks. The DNS/designee conducts audits of five random residents to verify that each resident has their own personal items and only their individual personal items used for them. These audits are conducted 5 times per week for 4 weeks, 3 times per week for 4 weeks and 1time per week for 4 weeks. These audits will include visualization of hair care completion to ensure resident appropriate item is being used. On 5/27/2023 resident hair brushes were thrown away and replaced to ensure each resident has their own hair brush which is labeled with their initials. MONITORING The Director of Nursing Services brings the results of the of the Infection Prevention Monitoring records to the Quality Assurance Performance	

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 05/25/2023

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 880	Continued From page 14 taking off the contaminated gloves CNA #2 touched the door handle and opened the door then removed the contaminated gloves, and exited the room without performing hand hygiene. Immediately after the CNA left the room she entered the common dining area and touched glasses and silverware that was placed in front of other residents. a. Interview with CNA #2 at that time confirmed she should have washed her hands before providing peri care, before leaving the resident's room, and before touching other resident's belongings. 4. Observation on 5/24/23 at 8:57 AM showed CNA #2 assisting resident #13 in the bathroom after an episode of diarrhea. While providing peri care to the resident, CNA #2 reached into the inside of the wipe's container several times to obtain fresh wipes. Interview with CNA #2 at that time revealed she was unaware she should not place her contaminated gloved hands into a clean container. 5. Interview with the DON on 5/25/23 at 3:15 PM revealed it was the facility's expectation for staff to provide proper peri care, hand hygiene, incontinence care, and not use communal grooming tools.	F 880	Improvement Committee monthly for their review and resolution. These audits will continue 5 times a week for 4 weeks, 3 times per week for 4 weeks and then 1 time per week for 4 weeks. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	