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 _____	08/07/2024

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 8/4/24 to 8/7/24. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		9/9/24

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

Electronically Signed | 08/30/2024

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 _____	08/07/2024

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 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. 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 a care plan was developed for 1 of 2 sample residents (#10) with post-traumatic stress disorder. The findings were: 1. Review of the quarterly MDS assessment dated 5/31/24 showed resident #10 had a BIMS score of 12 out 15, which indicated the resident was cognitively intact, and diagnoses which	F 656	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	

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 _____	08/07/2024

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 656	Continued From page 2 included anxiety disorder, depression, bipolar disorder, psychotic disorder, schizophrenia, and post-traumatic stress disorder. Review of a PASRR Level II review dated 4/16/23 showed recommended services included individual therapy. The following concerns were identified: a. Review of the care plan last revised on 6/30/24 showed no evidence a care plan was developed related to behavioral health related to post-traumatic stress disorder or bipolar disorder. d. Interview with the social services assistant on 8/6/24 at 10:57 AM revealed the resident did not receive any behavioral health support and she was not aware residents needed to receive behavioral health services. 2. Review of the policy titled "Trauma-informed care" last revised October 2022 showed "...1. Upon new admissions, the trauma-informed care evaluation is completed by the Licensed Nurse. 2. Based on the evaluation results, the appropriate provider and IDT notifications are made to support the care of a resident with past or present history of trauma. 3. The resident's care plan is updated to reflect goals and interventions including non-pharmacological means to provide care for the resident..."	F 656	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. F656 CORRECTIVE ACTION The care plan for resident #10 was revised by the social worker to include specific interventions to prevent trauma related to PTSD on 8/15/24 and developed a care plan for bipolar disorder on 8/23/24. IDENTIFICATION OF OTHERS An audit of the resident□s care plans was completed prior to 8/31/24 by the social service team to identify any residents with behavioral health issues to verify that each resident had a care plan which included specific interventions to address behavioral health. Any resident identified had a care plan added. SYSTEMIC CHANGE Upon admission or change of condition, the social worker reviews diagnosis to identify a behavioral health diagnosis. The social worker develops a care plan that is specific to that individual to address their behavioral health needs. Education was provided to the social	

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 _____	08/07/2024

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 656	Continued From page 3	F 656	service team on 8/29/24 by the Executive Director related to developing care plans that address behavioral health concerns that are specific to the individual. The social service team tracks the diagnosis of newly admitted residents or residents that have had a behavioral health diagnosis added to ensure that the care plans are revised to address these diagnosis. MONITORING The Social Worker brings the results of the diagnosis tracking/care plan development to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.	F 679		9/9/24

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 _____	08/07/2024

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 679	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure resident activities of interest were provided for 1 of 1 sample resident (#12) with activity concerns. The findings were: 1. Review of the quarterly MDS assessment dated 1/15/24 showed resident #12 had a [BIMS] score of 15 out of 15, which indicated s/he was cognitively intact, and diagnoses which included anxiety disorder and schizophrenia. Review of the activities care plan last revised on 2/19/24 showed the resident had little or no activity involvement related to "[s/he] wishes not to participate. [Resident name] enjoys music." Interventions included explaining the importance of social interaction, encourage participation, invite/encourage family members to attend activities with the resident, assist/escort the resident to activity functions, and remind the resident s/he can leave activities at any time. The following concerns were identified: a. Interview with the resident on 8/5/24 at 11:08 AM revealed the facility did not offer activities s/he would like to attend and the facility did not provide one-to-one activities for the resident; however, s/he revealed "It would be nice if they did." b. Review of an activity progress note dated 5/7/24 showed the resident had "no activity participation" and the resident enjoyed visits from his/her father and watching television. c. Interview with the activity director on 8/6/24 at 2:44 PM revealed the resident did not participate in activities and activity staff performed one-to-one activities; however, she was unable to	F 679	F 679 CORRECTIVE ACTION Resident #12 was interviewed by the Activity Director on 8/5/24 to discuss activities of interest that he/she would like to attend. A new 1:1 program was developed and implemented for resident#12 on 8/5/24 by the Activity Director to include specific activities that the resident enjoys that he/she is not doing by themselves. His/her care plan was updated on8/29/24 to reflect this change. IDENTIFICATION OF OTHERS Center residents were re-interviewed as to their activity preferences on 8/29/24 by the Activity Team care plans were updated as needed. An audit was conducted on 8/29/24 by the activity Director of the residents who receives 1:1 programing from the Activity Department to identify any other resident who may need more specific 1:1 activities with the Activity Team. Systemic Change Upon admission or with a change in the activity participation, the Activity Director/designee discusses activity preferences with the resident/family. In	

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 _____	08/07/2024

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 679	Continued From page 5 say what type of one-to-one activities were performed which the resident was unable to do independently. Further she revealed the care plan should indicate the resident's activities. 2. Review of the policy titled "Activity Program" last revised July 2015 showed "...5. Activities include individual, small and large groups, one-to-one, and independent activities to meet resident's needs, abilities, and interests. For residents confined to, or who choose to, remain in their room, the Activity Department provides and assists with in-room activities/projects/leisure pursuits in keeping with needs, abilities, and interests..."	F 679	addition, the resident is assessed for the potential to benefit from a structured 1:1 program with the Activity Team. If it is identified that the individual will benefit from 1:1 programing the Activity Director develops a specific program for the resident that involves participation from the activity team member. The care plans are updated with changes. The Activity Team was provided in-service education related to this process on8/12/24 by the Activity Director. MONITORING The Activity director evaluates the activity preferences and 1:1 programing and brings any trends or patterns to the to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		9/9/24

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 _____	08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 6 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, review of payroll-based journal (PBJ) data, and review of facility staff postings, the facility failed to ensure sufficient nursing staff was provided to ensure sufficient nursing staff to provide resident care. The census was 83. The findings were: 1. Interview with resident #13 on 8/4/24 at 2:15 PM revealed the facility did not have enough staff. Interview with the resident on 8/5/24 at 9:59 AM revealed the facility had set days for showers but "It doesn't always work out that way due to short staffing." The resident revealed s/he cannot sit up in the wheelchair for very long due to pain and staffing was "short" which made him/her not want to get up as it resulted in longer periods of sitting and increased pain.	F 725	F 725 Sufficient Nursing Staff CORRECTIVE ACTION Resident #13 was interviewed by the DNS on 8/28/24 stated he/she no unmet needs at this time. Resident #41 was interviewed by the DNS on 8/28/24 and he/she stated his/her need were met. He/she did state that he/she would like a male staff member to do his/her bed baths and showers. His/her care plan was up dated. Resident #75 was interviewed on 8/28/24 by the DNS. He/she stated he/she does not have any unmet needs	

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 _____	08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 7 2. Interview with resident #41 on 8/4/24 at 2:15 PM revealed "there is not enough CNAs. It can take 45 minutes to 1 hour to answer call bells." 3. Interview with resident #75 on 8/5/24 at 2:38 PM revealed there was not enough CNAs and "staff does not fill water mugs." 4. Interview with resident #58 on 8/5/24 at 11 AM revealed his/her call light was not always answered and "they definitely don't have enough [staff]." 5. Interview with resident #9 on 8/5/24 at 1:57 PM revealed "the first thing out of their mouth is they're understaffed; they don't have enough staff tonight. I hear this every night. There's only 1 of them here instead of 2." The resident stated "it's gotten bad" in reference to answering the call light. 6. Interview with resident #14 on 8/5/24 at 10:11 AM revealed the facility needed more staff on all shifts and s/he was unable to get help in a timely manner. 7. Interview with resident #60 on 8/5/24 at 9:49 AM revealed the facility did not have enough staff to provide assistance to residents. 8. Interview with resident #45 on 8/5/24 at 1:45 PM revealed staffing was "ok;" however, sometimes the resident did not receive showers because there was not enough staff. 9. Interview with resident #12 on 8/5/24 at 11:08 AM revealed the facility did not have enough staff and s/he had to wait between 35 and 40 minutes to get assistance.	F 725	Resident #58 was interviewed by the DNS on 8/28/24. His/her only response to the interview was "no one knows how to cook eggs here." A concern form was completed to address this issue. Resident #9 was interviewed by the DNS on 8/28/24. He/she stated all of his/her needs are met. Resident #14 was interviewed by the DNS on 8/28/24. He/she stated that his/her care is completed how it should be. Resident #60 was interviewed by the DNS on 8/28/24. He/she stated she has no unmet needs. Resident #45 was interviewed by the DNS on 8/28/24. He/she stated yep, all my needs are met and glad to be home. Resident #12 was interviewed by the DNS on 8/28/24. When asked if he/she had any unmet needs he/she replied no, my needs are all met. Resident #32 was interviewed on 8/28/24. He/she stated he/she had no unmet needs. IDENTIFICATION OF OTHERS All Center residents have the potential to be affected by this practice. SYSTEMIC CHANGE	

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 _____	08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 8 10. Interview with resident #32 on 8/5/24 at 10:48 AM revealed the facility did not have enough staff and resident had to wait between 30 and 40 minutes for someone to answer the call light. Further interview revealed, at times, staff would enter his/her room, shut off the call light without providing assistance and s/he did not always get showers as scheduled. 11. Observation of 3rd floor on 8/4/24 at 4:58 PM showed 2 CNAs assisting residents with care and answering call lights. Interview with CNA #3 at that time revealed staffing was not sufficient to provide care to residents. 12. Observation of 2nd floor on 8/5/24 at 9:46 AM showed there were 2 CNAs assisting residents with care and answering call lights. Interview at that time with CNA #2 confirmed 2nd floor had 2 CNAs and she revealed it was supposed to be staffed with 3 CNAs. She revealed staff were unable to provide care to 43 residents with 2 CNAs and some residents did not receive showers or other types of care. 13. Interview with LPN #1 on 8/5/24 at 5:26 PM revealed "this staffing [during the survey] is not normal, usually it's only 1 nurse and 1 CNA on this unit. 2nd floor only has 2 aides. Sometimes the food is an hour late." 14. Review of payroll-based journal (PBJ) data for the previous 4 quarters showed low weekend staffing and 1 star staff rating triggered for all 4 quarters. 15. Review of facility staff posting on 8/7/24 at 8:45 AM revealed NA (nurse aide) hours were	F 725	The Center runs consistent ads for nurses and C.N.A.s. The ads are refreshed to ensure that they have the most prominent position on the job websites. The Center is advertising on more than 80 job sites. The application website is checked multiple times per day in order to ensure quick communication with applicants and to invite applicants for an interview. The nursing administration team maintains a flexible schedule in order to interview applicants at the times that are most convenient for the applicant. Currently the Center offers referral bonuses and sign on bonuses for nursing and C.N.A. positions. The center also offers a shift differential for the weekend to encourage nursing personnel to work the weekend. The receptionist tracks all applicants and their progression through the hiring process to assist the applicant with a quick transition from applicant to employee and to assist them with any obstacles they may encounter. The receptionist keeps the DNS and the staffing coordinator up to date on their progression, as well as notifying them if the applicant fails to complete the process and why. As soon as the hiring process is complete, orientation is scheduled in order to get the employee on the schedule and working. The DNS/designee interviews 5 random residents per week to ensure that all of their needs are being met by the staff. If a concern is identified, it is addressed at that time.	

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 _____	08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 9 included in the daily staff posting. 16. Interview with the DON on 8/6/24 at 3:52 PM revealed the facility did not employ NAs, they use hospitality aides (HSA), which were unable to provide resident care, and the HSAs hours were indicated as NA on the daily staff posting. 17. Review of Hospitality Aide job description on 08/07/24 at 8:30 PM showed "...the Hospitality Aide may not perform direct patient care ..." 18. Review of facility wide self-assessment dated 5/17/24 showed the facility required 160 care hours for CNAs with an average census of 84. 19. Review of the daily staff postings for July 2024 showed the facility had an average of 148 hours for CNAs and an average daily census of 83.2 20. Interview with the nursing staffer on 8/7/24 at 8:36 AM revealed the corporation provides minimum staffing based on resident census. She revealed minimum staffing on day shift and evening shift would be 3 CNAs for 2nd floor, 2 CNAs on 3rd floor, and 1 CNA in the secure unit. She revealed night shift minimum staffing would be 2 or 3 CNAs on 2nd floor, depending on the census, 2 CNAs on 3rd floor, and 1 CNA in the secure unit. Further interview confirmed HSAs were not able to provide direct resident care; however, they were counted as part of and figured into the daily nursing staff hours.	F 725	MONITORING The DNS brings the results of the hiring tracking and resident interviews to the to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive	F 742		9/9/24

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 _____	08/07/2024

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 742	Continued From page 10 assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; 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 behavioral health services were provided to 1 of 2 sample residents (#10) with post-traumatic stress disorder. The findings were: 1. Review of the quarterly MDS assessment dated 5/31/24 showed resident #10 had a BIMS score of 12 out 15, which indicated the resident was cognitively intact, and diagnoses which included anxiety disorder, depression, bipolar disorder, psychotic disorder, schizophrenia, and post-traumatic stress disorder. Review of a preadmission screening and resident review (PASARR) Level II review dated 4/16/23 showed recommended services included individual therapy. The following concerns were identified: a. Review of a social services note dated 4/25/24 and timed 10:09 AM showed the facility contacted a behavioral health facility, at the request of the resident, to schedule mental health services. The behavioral health facility sent paperwork to be completed and returned prior to scheduling an appointment. Review of a social services note dated 4/29/24 and timed 10:32 AM showed the facility contacted the behavioral health facility as the required paperwork was not	F 742	F 742 CORRECTIVE ACTION An appointment is scheduled for 9/18/24 for behavioral health services with LIV Heath related to resident #10□s mental health needs. IDENTIFICATION OF OTHERS An audit was completed on 8/20/24 by the social worker of the residents with PASRR Level II□s to identify any resident who may have a recommendation for individual therapy services who may not currently be receiving therapy. Any individual identified has been asked if they would like therapy services. Referrals have been made for any resident who□s PASRR Level II indicates therapy services who desires therapy. Systemic Change Upon admission and with a change in the PASRR Level II, the Social Worker	

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 _____	08/07/2024

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 742	Continued From page 11	F 742		

received.

b. Review of a social services note dated 7/29/24 and timed 11:58 showed the behavioral health facility was unable to accept new patients and social services was going to speak with the resident about scheduling with a new provider.

c. Review of the care plan last revised on 6/30/24 showed no evidence a care plan was developed for behavioral health related to post-traumatic stress disorder or bipolar disorder.

d. Interview with the social services assistant on 8/6/24 at 10:57 AM revealed in April, the resident was experiencing some grief and she attempted to schedule behavioral health services. The social services assistant revealed she thought the services had been scheduled; however, when she called and checked in July, she was told they were not accepting new patients. Further interview revealed the resident did not receive any behavioral health support and she was not aware residents needed to receive behavioral health services.

2. Review of the policy titled "Trauma-informed care" last revised October 2022 showed "...1. Upon new admissions, the trauma-informed care evaluation is completed by the Licensed Nurse. 2. Based on the evaluation results, the appropriate provider and IDT notifications are made to support the care of a resident with past or present history of trauma. 3. The resident's care plan is updated to reflect goals and interventions including non-pharmacological means to provide care for the resident..."

3. Review of the policy titled "Mental Health Rehabilitation Services" last revised July 2015 showed "...1. Social Services review all residents receiving a Level II PASARR screening for

reviews the recommendations to ensure that individual therapy services are provided as recommended if the resident chooses to participate in therapy. The care plan is updated to reflect recommendations related to individual therapy and resident choice.

In-service education was provided to the social workers by the Executive Director regarding reviewing and implementation of recommendations for therapy on the PASRR Level II□s on 8/29/24.

MONITORING

The Social Workers trends the PASRR Level II recommendations and referrals for therapy and brings any identified patterns to the to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.

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 _____	08/07/2024

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 742	Continued From page 12 indication of mental health rehabilitation services. 2. The services are coordinated by Social Services and performed by qualified professionals from inside the Center or from community as provided or arranged through state agency..."	F 742		
F 758 SS=E	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; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		9/9/24

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 _____	08/07/2024

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 13 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, staff interview, and policy and procedure review, the facility failed to ensure target symptoms were identified and monitoring of target symptoms was completed for 1 of 5 sample residents (#10) reviewed for unnecessary psychotropic medications. The findings were: 1. Review of the quarterly MDS assessment dated 5/31/24 showed resident #10 had a BIMS score of 12 out 15, which indicated the resident was cognitively intact, and diagnoses which included anxiety disorder, depression, bipolar disorder, psychotic disorder, schizophrenia, and post-traumatic stress disorder. Review of the physician's orders showed the resident received risperidone (antipsychotic) 2 milligrams (MG) by mouth daily for schizoaffective disorder and buspirone (antianxiety) 10 MG by mouth 3 times per day for anxiety disorder. The following	F 758	F 758 CORRECTIVE ACTION The Psych/drug committee reviewed the specific target symptoms for resident #10 on 8/14/24 and added specific target symptoms for each medication he/she receives. The specific target symptoms were added to the care plan, symptom monitoring and the Psychotropic Drug and Behavior Evaluation. IDENTIFICATION OF OTHERS The psych/drug committee reviewed all residents who receive psychotropic medication to ensure that specific target symptoms were added for each medication. Any identified specific target	

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 _____	08/07/2024

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 14 concerns were identified: a. Review of the care plan last revised on 7/23/24 showed no evidence the facility identified resident specific target symptoms for each medication. b. Review of the medication administration record for June, July, and August 2024 showed no evidence the facility identified resident specific target symptoms for each medication or had a process to monitor resident specific target symptoms. 2. Interview with the DON on 8/7/24 at 11:04 AM confirmed the target symptoms had not been identified as medication specific and revealed the facility was unable to evaluate the effectiveness of medications. 3. Review of the policy titled "Psychotropic Drugs" last revised October 2022 showed "...2. Psychotropic drugs can be therapeutic and enhancing quality of life for residents suffering from mental illnesses (schizophrenia, depression, etc.), the Interdisciplinary Team (IDT) validates there are appropriate diagnoses of behavioral symptoms, so the underlying cause of the symptoms is recognized, and the condition is treated appropriately..."	F 758	symptoms were added to the care plan, behavior monitoring and the Psychotropic Drug and Behavior Evaluation. This was completed on 8/30/24. SYSTEMIC CHANGE Each resident who receives psychotropic medications is reviewed monthly to discuss current medication, diagnosis, specific target symptoms, non-pharmacological interventions and possible GDR by the Psych/drug Committee. During this committee meeting, the care plan, target symptom monitoring and the Psychotropic Drug and Behavior Evaluation are reviewed. Specific target symptoms are added as needed. In-service education was provided to the members of the Psych/Drug Committee on 8/29/24 by the DNS regarding the requirements of each medication to have specific target symptoms identified. The Social Workers monitor the changes to the specific target symptoms to verify that the specific target symptoms are appropriate for each medication, accurate for each resident and are annotated on the care plan, symptom monitoring and the Psychotropic Drug and Behavior Evaluation with any change. MONITORING The Social Worker monitors the specific target symptoms for those resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	08/07/2024

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 15	F 758	reviewed in the Psych/drug Committee weekly to ensure that specific target symptoms are identified with each medication added or changed and are appropriate for the individual resident. The Social Worker brings any trends or patterns related to the posting to the to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		9/9/24

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 _____	08/07/2024

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 761	Continued From page 16 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure medications available for resident use were not expired in 1 of 3 storage areas (2nd floor medication room). The findings were: 1. Observation of the 2nd floor medication storage room refrigerator on 8/5/24 at 4:44 PM showed a box of Bisacodyl (laxative) suppositories with an expiration date of "7/24." Review of the manufacturer's literature indicated not to use after the expiration which was on the carton and blister. Further review showed the expiration date referred to the last day of that month. 2. Interview with RN #1 on 8/5/24 at 4:44 PM revealed the all medications stored in the medication storage room refrigerator were available for resident use. 3. Review of the policy titled "House Supplied (Floor Stock) Medications" dated 1/23 showed " ...Floor stock medications kept in the original manufacturer's container must have expiration date and lot numbers clearly visible. Unless otherwise specified, the expiration date is limited to the expiration date on the original container or one years' time from date of opening, whichever comes first..."	F 761	F 761 Corrective Action The Suppository was disposed of on 8/6/24 by the Director of Nursing. Identification of Others Any resident who has an order for a suppository has the potential to be affected by this practice. Systemic Change The night nurse audits the medications in the medication refrigerators and validates that there are no expired medications in the refrigerator. If a medication is found to be expired it is disposed of at the time of identification. The nurse signs off nightly that the audit has been completed and notes what if any medications were disposed of. In-service education was provided to the licensed nursing staff on 8/28/24 related to auditing for and disposal of expired medications by the DON. The DON/designee randomly spot checks the refrigerators for any expired medications and educates any nurse who	

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 _____	08/07/2024

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 761	Continued From page 17	F 761	may have missed disposal of the medication. Monitoring The Director of Nursing monitors the medication audit sheets for possible patterns and trends for expired medications. Any identified risks are reviewed with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This will continue for 3 months. 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=D	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	F 880		9/9/24

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 _____	08/07/2024

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 18 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 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	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 _____	08/07/2024

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 19 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 professional standard of practice review, the facility failed to ensure infection prevention practices were implemented during for 1 of 2 sample residents (#81) observed for personal care. The findings were: 1. Review of the admission MDS assessment dated 4/9/24 showed resident #81 had a BIMS score of 9 out 15, which indicated moderate cognitive impairment, and diagnoses which included benign prostatic hyperplasia and cerebrovascular accident. Further review showed the resident had an indwelling catheter, was always continent of bowel, and was dependent on staff for toileting hygiene. The following concerns were identified: a. Observation on 8/6/24 at 8:58 AM showed CNA #1 assisted the resident to his/her room, applied a gown, gloves, and facemask, and prepared to transfer the resident from the wheelchair to bed. The CNA placed the resident's catheter drainage bag on her gown, positioning it above the resident's bladder, and allowed visible urine in the tubing to flow backward toward the resident's bladder. After being unable to find a gait belt, the CNA placed the drainage bag under the resident's wheelchair, and removed a gait belt from her torso, under her gown. The CNA applied the gait belt to the resident's torso and again placed the resident's catheter drainage bag on	F 880	F 880 Corrective Action C.N.A. #1was provided 1:1 education on 8/6/24 regarding appropriate catheter placement and education on prevention of cross contamination regarding incontinence wipes by the DNS to ensure that resident #81 is provided appropriate care to ensure Infection Control Measures. C.N.A. #1 provided return demonstration on appropriate technique for catheter placement and utilization of incontinence wipes to prevent cross contamination after receiving verbal, written and visual education. All open incontinence wipes in resident #81□s room were thrown away and replaced on 8/6/24. Identification of Others All residents who require incontinence care or have catheters are at risk to be affected by this practice. All residents who are incontinent or have	

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 _____	08/07/2024

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 20 her gown, above the resident's bladder, which allowed the visible urine in the tubing to flow backward toward the resident's bladder. CNA #2 assisted CNA #1 to transfer the resident into bed. CNA #1 placed the resident's catheter drainage bag in a pink basin by the resident's bed, and removed the resident's pants. CNA #1 performed perineal care to the resident, cleaning the resident front to back and clean to dirty; however, the resident was incontinent of stool and, after removing feces from the resident's rectal area, the CNA used her contaminated gloved hand to obtain more wipes from inside the wipe container. b. Interview with the DON on 8/6/24 at 3:04 PM confirmed the catheter drainage bag should not have been raised above the resident's bladder and the CNA should not have used her contaminated hand to obtain additional wipes from the wipe container. 2. Review of Perry/Potter seventh edition "Nursing Interventions & Clinical Skills" copyright 2020 showed "...Care and Removal of an Indwelling Catheter...Implementation...Routinely check drainage tubing and bag...e. drainage bag is positioned below level of the bladder with urine flowing freely into bag..."	F 880	catheters were identified and incontinence wipes were disposed of and replaced with new wipes on 8/6/24. Systemic Change The nursing staff was provided in-service education by the DNS on 8/28/24 regarding infection control techniques while providing incontinence care to prevent cross contamination. The nursing staff was provided in-service education by the DNS on 8/28/24 regarding appropriate catheter placement. The DNS/designee monitors infection control practices related to incontinence care of random nursing staff members twice a week on varying shifts to validate that the nursing staff members are using appropriate infection control practices when providing incontinence care. Any identified concerns are addressed with the staff member. The DNS/designee monitors random staff members on varying shifts for catheter placement during cares for appropriate placement of the catheter twice per week. Any identified concerns are addressed with the staff member. Monitoring The Director of Nursing reviews the incontinence care and catheter placement monitoring for patterns or trends. Any	

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 _____	08/07/2024

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 21	F 880	identified areas of concern are reviewed with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	