

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Granite Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 3128 Boxelder Drive Cheyenne, WY 82001	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081</p> <p>Based on observation, resident, resident representative, and staff interview, and grievance log review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 4 grievance areas (food service and palatability). The census was 72. The findings were:</p> <ol style="list-style-type: none"> Review of a grievance form dated 1/9/24 showed the daughter of resident #1 was angry the resident was getting a roommate and stated the resident was only served a small amount of soup . Further review showed Action Taken: Interview with RD [registered dietitian] who was assisting /monitoring meal observed resident bowls appropriately filled .Resident discharged AMA on 1/9/24 .prior to resident leaving dinner tray was observed and was consistent with what resident ordered for dinner. Soup bowl empty with soup ring at appropriate level . Review of a grievance form dated 3/12/24 showed resident #2 reported breakfast is always cold and was promised lunch would be saved and reheated upon arrival from dialysis. The review showed Department Manager Investigation and Findings: Was brought up at resident meeting. I checked with [resident name] and [s/he] said everything was much better .Action Taken: Kitchen was notified. We are now heating residents [sic] meals appropriately when [s/he] is gone for meetings . Further review showed the grievance was not marked as resolved or unresolved. Review of a grievance form dated 3/21/24 showed resident #3 reported Resident did not like dinner meal, [s/he] was very disappointed and refused to eat, [s/he] was offered an alternate and as refused that because [s/he] said [his/her] appetite was ruined. Further review showed Department Manager Investigation and Findings: Spoke with resident [s/he] stated [s/he] would just start eating McDonalds because management sucks .Action taken: We are changing this meal to grilled cheese and tomato soup from now on . Review of a grievance form dated 3/21/24 showed resident #4 reported Resident said [his/her] dinner was not fit to eat. The dinner was French onion soup with grilled cheese sandwich and German cucumber salad. Further review showed Department Manager Investigation and Findings: Spoke with resident. [S/he] did not remember the grievance but was thankful the menu would be changed .Action Taken: We are on a new menu and will be changing this menu to tomato soup and grilled cheese . Review of a grievance form dated 4/2/24 showed 5 residents reported chicken over cooked, meal slow, not flavorful. Further review showed Department Manager Investigation and Findings: [NAME] no longer here, new cook hired . <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Review of a grievance form dated 4/2/24 showed resident #5 reported Dinner was supposed to start at 4:30 PM. It is now 6 PM and we have yet to be served anything other than beverages. Further review showed Department Manager Investigation and Findings: Dinner service starts at 5:30, Working with staff on timing.</p> <p>8. Review of a grievance form dated 4/7/24 showed resident #6 reported clearly ordered turkey sandwich no cheese was given ham. Further review showed Department Manager Investigation and Findings: Resident was given turkey sandwich after was served ham .Action Taken: Staff was instructed to serve the proper meal that was ordered.</p> <p>9. Review of a grievance form dated 4/8/24 showed resident #7 reported tomato soup is burned. Food is late and cold. I don't always get what I order. Further review showed Department Manager Investigation and Findings: Statements are true. Corrective actions have been taken. Corrective action taken with staff .Action Taken: Retrain staff.</p> <p>10. Review of a grievance form dated 4/9/24 showed resident #2 reported Grill [sic] cheese sandwich was burnt again. Bosses went home and no one else would fix another one. Had 1/2 egg salad sand and 4 strips [NAME] [chicken] for dinner. Further review showed Department Manager Investigation and Findings: Meeting was held. assured [him/her] I am here long days. New cook is cooking manager in center for all 3 meals. Served Cesar [sic] salad [with] chicken .Action Taken: New cook making grilled cheese Egg salad sand [sandwich] served as snack only. Alternates were available.</p> <p>11. Observation on 4/10/24 showed residents on second floor were seated at tables, waiting for lunch service, by 12 PM. Further observation showed the meal service in the 2nd floor dining room began at 1 PM.</p> <p>12. Observation on 4/11/24 showed lunch service on second floor began at 1:02 PM. Further observation showed the meal service was stopped at 1:12 PM to obtain additional hoagie buns and 1 resident was served a meatball sandwich on a hamburger bun at 1:30 PM because the facility ran out of hoagie buns a second time during meal service. All meals were served by 1:30 PM. Interview with resident #8 at that time revealed the meal was cold.</p> <p>13. Interview with resident #35 on 4/10/24 at 11:59 AM revealed residents had recently discussed meal concerns during resident council; however, they were trying to be understanding of a recent tragedy suffered by dietary staff members.</p> <p>14. Interview with resident #34 on 4/10/24 at 2:50 PM revealed meat served with meals was not thoroughly cooked and the only alternatives offered were sandwiches or soup. The resident revealed the facility reported dining concerns were related to not having enough staff and not being able to hire new staff. Further interview revealed the meals were always late, up to an hour, and the facility did not respond to resident concerns.</p> <p>15. Interview with resident #30 on 4/10/24 at 3:09 PM revealed meals were always late, were not cooked properly, did not follow the menu, and had small portions.</p> <p>16. Interview with resident #31 on 4/10/24 at 3:10 PM revealed the facility reported they had seven dietary staff members recently quit and the food was not cooked well. The resident revealed meals were served an hour after they were supposed to be and the portions kept getting smaller.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>17. Interview with the administrator and dietary manager on 4/12/24 at 9:15 AM revealed meals were scheduled to be served at 7:30 AM, 12 PM, and 5:30 PM. They revealed the dietary department had turned over pretty much all the staff and had recently changed food providers. The new menu required meals to be made from scratch and they were still training new staff. They revealed 2 staff members in dietary were off due to a traumatic event and food service issues had been ongoing. Further interview revealed there were three additional staff openings in dietary and performance improvement plan had been developed; however, it had not been fully implemented at that time and the dietary concerns had not been resolved.</p> <p>18. Interview with the social services director on 4/12/24 at 11:50 AM revealed residents could verbalize or write down grievances. After grievances were received, they were passed on to the department manager to address. The social services director revealed the department manager was responsible for resolution and notification of individuals who filed the grievance. Further interview confirmed the meal concerns had not been resolved.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081</p> <p>Based on observation, resident, resident representative, and staff interview, medical record review, and facility grievance review, the facility failed to ensure bathing was performed per the plan of care on 2 of 2 resident care units (second floor, third floor). The census was 72. The findings were:</p> <ol style="list-style-type: none"> 1. Review of a Grievance Form dated 3/12/24 showed resident #7 reported s/he was not being asked if s/he wanted a shower; however, it was documented s/he refused. Further review showed Department Manager Investigation and Findings: Times the I'm asked don't work with activities, I would like later showers and Actions/Recommendations: Shower times changed to evenings 2. Review of the .ADL self-care performance . care plan last revised on 1/10/24 showed resident #1 prefers to bathe/shower twice weekly and PRN and Provide sponge bath when a full bath or shower cannot be tolerated. The following concerns were identified: <ol style="list-style-type: none"> a. Review of the bathing record between 12/1/23 and 1/15/24 showed the resident had showers documented as being provided on 14 times during the period and a bed bath was documented twice on the same day. b. Interview with the resident on 4/11/24 at 12:46 PM revealed s/he discharged from the facility following care and food concerns by him/her and family. S/he revealed s/he only received 2 showers during his/her short stay, the first shower was provided 3 weeks after s/he admitted to the facility and the second was given 2 weeks later. Further interview revealed the resident's daughter voiced concerns about care and food to the facility; however, nothing was done to correct it. c. Interview with the resident's representative on 4/11/24 at 3:18 PM confirmed the resident was discharged due to concerns with care and food while the resident was at the facility. Further interview revealed the resident did not receive showers as frequently as s/he was supposed to. 3. Review of the . ADL self-care performance . care plan last revised on 3/30/24 showed resident #22 prefers to bathe/shower twice weekly and PRN. The following concerns were identified: <ol style="list-style-type: none"> a. Observation on 4/10/24 at 11:51 AM showed a sour body odor smell was present in the hallway, on second floor B hall, near the room of resident #22. b. Observation on 4/10/24 at 3:02 PM showed the resident had a sour body odor present in his/her room. Interview with the resident at that time revealed s/he received bed baths in lieu of showers due to showers being hard on him/her. Further interview revealed s/he would prefer to take a shower; however, it was easier on him/her and for staff to perform a bed bath. c. Review of the bathing record between 1/11/24 and 4/8/24 showed the resident received a shower 6 times on 1/17/24, 2/1/24, 2/15/24, 2/28/24, 3/4/24, 3/10/24 and 4/1/24; however, the resident was also documented as refused on 2/1/24. Further review showed the resident received a bed bath 23 times during the time period. <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of the medical record showed resident #6 was admitted on [DATE] and was scheduled for bathing on Tuesday and Fridays. The following concerns were identified:</p> <p>a. Observation on 4/10/24 at 3:10 PM showed the resident required a lift and 2 people to transfer, assist with positioning and hygiene/grooming assistance. The resident was provided a partial bed bath, during the transfer, to include peri-care with wipes. Interview with the resident at that time revealed the resident would prefer a shower; however, the water got cold before the shower is completed so a bed bath was routinely performed.</p> <p>b. Review of the bathing record between 1/11/24 through 4/8/24 showed the resident had not received a shower and had received 18 bed baths.</p> <p>5. Review of the plan of care showed resident #29 preferred a shower on Tuesday and Friday evenings. The following concerns were identified:</p> <p>a. Observation of the resident on 4/10/24 at 1:05 PM showed the resident was wheelchair bound and dependent on others for ADLs. The resident's hair that was long and appeared greasy.</p> <p>b. Review of the bathing record for February 2024, March 2024, and April 2024 showed the resident received 9 showers, 7 bed baths and had 9 documented refusals. The resident's last shower was provided on 4/5/24.</p> <p>6. Observation on 4/11/24 at 1:23 PM of resident #17 showed the resident was in isolation for infection prevention, sitting in a wheelchair. Interview with the resident at that time revealed the resident was admitted 2 days prior and was offered a shower the second night s/he was at the facility and the resident stayed up as late as I could;" however, nobody arrived for the shower. The resident further revealed that on the morning of the interview a CNA offered a shower and when the resident agreed the resident was told that only a bed bath was available, not a shower, so the resident declined the bed bath and stated, so I am still in my pajamas. Interview with the resident's daughter on 4/11/24 at 11 AM confirmed the resident moved in on Tuesday (4/9/24) and during a visit on Wednesday evening, they were told the resident was on the shower list that night; however, the resident did not get a shower.</p> <p>7. Observation on 4/10/24 at 11:49 AM showed a sour body odor smell was present in the hallway, on second floor B hall, near the room of resident #36. Observation on 4/10/24 at 3:57 PM showed the sour body odor remained present near the room of the resident. Observation on 4/11/24 at 10:30 AM showed the resident's room had a sour body odor present. Interview with the resident at that time revealed the facility only provided the resident with bed baths; however, the resident stated it was his/her choice.</p> <p>8. Interview with resident #31 on 4/10/24 at 3:10 PM revealed some residents did not receive showers as often as they should and they had bad body odor. Further interview revealed s/he thought it was due to staff not wanting to use the mechanical lift to transfer residents to the shower.</p> <p>9. Interview with the social services director on 4/12/24 at 12:05 PM confirmed residents should be showered per their preference and if the resident refused a shower, they should receive a bed bath. Further interview revealed that resident #6 may not be aware that the hot water issues have been resolved and showers may be an option again in the future.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10. Interview with the DON on 4/12/24 at 11 AM revealed she expected staff to offer residents a shower and if they refused, offer a bed bath. She revealed the facility found out some staff members were only providing bed baths to residents who were on COVID precautions because they thought the residents could not leave their room for a shower. She revealed the facility had performed staff education because of a high number of resident refusals and documented bed baths. Further interview revealed the bed baths did not clean residents as thoroughly as a shower.</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>35081</p> <p>Based on observation, resident and staff interview, medical record review, and resident grievance form review, the facility failed to ensure adequate staffing in 1 of 1 kitchen (main kitchen). The census was 72. The findings were:</p> <ol style="list-style-type: none"> Review of a grievance form dated 3/12/24 showed resident #2 reported breakfast is always cold and was promised lunch would be saved and reheated upon arrival from dialysis. Further review showed Department Manager Investigation and Findings: Was brought up at resident meeting. I checked with [resident name] and [s/he] said everything was much better .Action Taken: Kitchen was notified. We are now heating residents meals appropriately when [s/he] is gone for meetings . Review of a grievance form dated 4/2/24 showed 5 residents reported chicken over cooked, meal slow, not flavorful. Further review showed Department Manager Investigation and Findings: [NAME] no longer here, new cook hired . Review of a grievance form dated 4/2/24 showed resident #5 reported Dinner was supposed to start at 4:30 PM. It is now 6 PM and we have yet to be served anything other than beverages. Further review showed Department Manager Investigation and Findings: Dinner service starts at 5:30, Working with staff on timing. Review of a grievance form dated 4/8/24 showed resident #7 reported tomato soup is burned. Food is late and cold. I don't always get what I order. Further review showed Department Manager Investigation and Findings: Statements are true. Corrective actions have been taken. Corrective action taken with staff .Action Taken: Retrain staff. Observation of a sign posted on the wall by the elevator on the 3rd floor showed residents meal times were: breakfast at 7:30 AM, lunch at 12 and supper at 5:30 PM. Observation on 4/10/24 showed residents on second floor were seated at tables, waiting for lunch service, by 12 PM. Further observation showed the meal service, in the 2nd floor dining room, began at 1 PM. Observation on 4/11/24 showed lunch service on second floor began at 1:02 PM. Further observation showed the meal service was stopped at 1:12 PM to obtain additional hoagie buns and 1 resident was served a meatball sandwich on a hamburger bun at 1:30 PM because the facility ran out of hoagie buns a second time during meal service. All meals were served by 1:30 PM. Interview with resident #8 at that time revealed the meal was cold. Observation of the 3rd floor lunch service on 4/10/24 at 11:56 AM the food arrived to the 3rd floor. Lunch service continued until 1:08 AM when the final resident meals were delivered. Observation of the lunch meal on 4/11/24 showed by noon there were 8 residents in the dining room and room trays were being delivered. At 12:40 PM there were 11 residents in the dining room and all residents were served by 12:50 PM. <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>9. Observation of resident #6 on 4/10/24 at 3:10 PM showed the resident had no teeth. Review of the medical showed the resident required a high protein diet for wound healing. Interview with the resident on 4/10/24 at 3:20 PM revealed the food served at the facility was too tough to chew and/or needed to be cut into bite sized pieces for the resident. The resident complained of the facility serving food that could not be eaten and meals that had been served progressively later than the meal time window. The resident had resorted to ordering fast food delivered and supplementing meals with protein shakes to meet food preferences and improve intake.</p> <p>10. Interview with resident #37 on 4/10/24 at 1 PM confirmed the food service was consistently slow and the result was cold food and/or long wait times for the meals to be delivered to the residents. An additional interview on 4/10/24 at 2:52 PM revealed the meals were often delivered cold and tasteless and the resident considered this a long time problem.</p> <p>11. Interview with the daughter of resident #17 on 4/11/24 at 11:05 AM revealed that the food served for dinner on Tuesday night was not appetizing to the resident so the daughter brought dinner in for the resident the second night. Further interview revealed the resident complained about receiving cold eggs for breakfast this morning.</p> <p>12. Interview with resident #38 on 4/11/24 at 10:20 AM revealed the meat served at meals was dry and tough and the vegetables were either mush or raw.</p> <p>13. Interview with resident #35 on 4/10/24 at 11:59 AM revealed residents had recently discussed meal concerns during resident council; however, they were trying to be understanding of a recent tragedy suffered by dietary staff members.</p> <p>14. Interview with resident #34 on 4/10/24 at 2:50 PM revealed meat served with meals was not thoroughly cooked and the only alternatives offered were sandwiches or soup. The resident revealed the facility reported dining concerns were related to not having enough staff and not being able to hire new staff. Further interview revealed the meals were always late, up to an hour, and the facility did not respond to resident concerns.</p> <p>15. Interview with resident #30 on 4/10/24 at 3:09 PM revealed meals were always late, were not cooked properly, did not follow the menu, and had small portions.</p> <p>16. Interview with resident #31 on 4/10/24 at 3: 10 PM revealed the facility reported they had seven dietary staff members recently quit and the food was not cooked well. The resident revealed meals were served an hour after they were supposed to be and the portions kept getting smaller.</p> <p>17. Interview with the administrator and dietary manager on 4/12/24 at 9:15 AM revealed meals were scheduled to be served at 7:30 AM, 12 PM, and 5:30 PM. They revealed the dietary department had turned over pretty much all the staff and had recently changed food providers. The new menu required meals to be made from scratch and they were still training new staff. They revealed 2 staff members in dietary were off due to a traumatic event and food service issues had been ongoing. Further interview revealed there were three additional staff openings in dietary and performance improvement plan had been developed; however, it had not been fully implemented at that time.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081</p> <p>Based on observation, resident and staff interview, review of grievance forms, and medical record review, the facility failed to ensure palatable food was served in 1 of 1 kitchen (main kitchen). The census was 72. The findings were:</p> <ol style="list-style-type: none"> 1. Review of a grievance form dated 3/21/24 showed resident #1 reported tortilla was dry and chewy, could not eat. Further review showed Discussed with resident. There was nothing unusual about tortilla, maybe it was the brand. 2. Review of a grievance form dated 3/12/24 showed resident #2 reported breakfast is always cold and was promised lunch would be saved and reheated upon arrival from dialysis. Further review showed Department Manager Investigation and Findings: Was brought up at resident meeting. I checked with [resident name] and [s/he] said everything was much better .Action Taken: Kitchen was notified. We are now heating residents meals appropriately when [s/he] is gone for meetings . 3. Review of a grievance form dated 3/21/24 showed resident #3 reported Resident did not like dinner meal, [s/he] was very disappointed and refused to eat, [s/he] was offered an alternate and as refused that because [s/he] said [his/her] appetite was ruined. Further review showed Department Manager Investigation and Findings: Spoke with resident [s/he] stated [s/he] would just start eating McDonalds because management sucks .Action taken: We are changing this meal to grilled cheese and tomato soup from now on . 4. Review of a grievance form dated 3/21/24 showed resident #4 reported Resident said [his/her] dinner was not fit to eat. The dinner was French onion soup with grilled cheese sandwich and German cucumber salad. Further review showed Department Manager Investigation and Findings: Spoke with resident. {S/he did not remember the grievance but was thankful the menu would be changed .Action Taken: We are on a new menu and will be changing this menu to tomato soup and grilled cheese . 5. Review of a grievance form dated 4/2/24 showed 5 residents reported chicken over cooked, meal slow, not flavorful. Further review showed Department Manager Investigation and Findings: [NAME] no longer here, new cook hired . 6. Review of a grievance form dated 4/7/24 showed resident #6 reported clearly ordered turkey sandwich no cheese was given ham. Further review showed Department Manager Investigation and Findings: Resident was given turkey sandwich after was served ham .Action Taken: Staff was instructed to serve the proper meal that was ordered. 7. Review of a grievance form dated 4/8/24 showed resident #7 reported tomato soup is burned. Food is late and cold. I don't always get what I order. Further review showed Department Manager Investigation and Findings: Statements are true. Corrective actions have been taken. Corrective action taken with staff .Action Taken: Retrain staff. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. Review of a grievance form dated 4/9/24 showed resident #2 reported Grill [sic] cheese sandwich was burnt again. Bosses went home and no one else would fix another one. Had 1/2 egg salad sand and 4 strips [NAME] [chicken] for dinner. Further review showed Department Manager Investigation and Findings: Meeting was held. assured [him/her] I am here long days. New cook is cooking manager in center for all 3 meals. Served Cesar salad [with] chicken .Action Taken: New cook making grilled cheese Egg salad sand [sandwich] served as snack only. Alternates were available.</p> <p>9. Observation on 4/11/24 showed lunch service on second floor began at 1:02 PM. Further observation showed the meal service was stopped at 1:12 PM to obtain additional hoagie buns and 1 resident was served a meatball sandwich on a hamburger bun at 1:30 PM because the facility ran out of hoagie buns a second time during meal service. All meals were served by 1:30 PM. Interview with resident #8 at that time revealed the meal was cold.</p> <p>10. Observation of resident #6 on 4/10/24 at 3:10 PM showed the resident had no teeth. Review of the medical record showed the resident required a high protein diet for wound healing. Interview with the resident on 4/10/24 at 3:20 PM revealed the food served at the facility was too tough to chew and/or needed to be cut into bite sized pieces for the resident. The resident revealed s/he was served food that could not be eaten and meals had been served progressively later than the meal time window. Further interview revealed the resident had resorted to ordering fast food delivery and supplementing meals with protein shakes to meet food preferences and improve intake.</p> <p>11. Interview with the daughter of resident #17 on 4/11/24 at 11:05 AM revealed that the food served for dinner on Tuesday night was not appetizing to the resident so the daughter brought dinner in for the resident the second night, in addition, that the resident complained about receiving cold eggs for breakfast this morning.</p> <p>12. Interview with resident #37 on 4/10/24 at 1 PM confirmed the food service was consistently slow and the result was cold food and/or long wait times for the meals to be delivered to the residents. An additional interview on 4/10/24 at 2:52 PM revealed the meals were often delivered cold and tasteless and the resident considered this a long time problem.</p> <p>13. Interview with resident #34 on 4/10/24 at 2:50 PM revealed meat served with meals was not thoroughly cooked and the only alternatives offered were sandwiches or soup. The resident revealed the facility reported dining concerns were related to not having enough staff and not being able to hire new staff. Further interview revealed the meals were always late, up to an hour, and the facility did not respond to resident concerns.</p> <p>14. Interview with resident #30 on 4/10/24 at 3:09 PM revealed meals were always late, were not cooked properly, did not follow the menu, and had small portions.</p> <p>15. Interview with resident #31 on 4/10/24 at 3: 10 PM revealed the facility reported they had seven dietary staff members recently quit and the food was not cooked well. The resident revealed meals were served an hour after they were supposed to be and the portions kept getting smaller.</p> <p>16. Interview with resident #38 on 4/11/24 at 10:20 AM revealed the meat served at meals was dry and tough and the vegetables were either mush or raw.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Granite Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 3128 Boxelder Drive Cheyenne, WY 82001	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>17. Interview with the administrator and dietary manager on 4/12/24 at 9:15 AM revealed dietary department had turned over pretty much all the staff and had recently changed food providers. The new menu required meals to be made from scratch and they were still training new staff. They revealed 2 staff members in dietary were off due to a traumatic event and confirmed food service issues had been ongoing. Further interview revealed performance improvement plan had been developed; however, it had not been fully implemented at that time. They confirmed the meal issues had not been corrected.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35081</p> <p>44506</p> <p>Based on observation, staff interview, and review of the facility's policy, the facility failed to ensure staff correctly donned personal protective equipment (PPE) prior to resident care for 1 of 5 sample residents (#17) who were on transmission-based precautions. The findings were:</p> <ol style="list-style-type: none"> 1. Observation on 4/10/24 at 12:05 PM showed resident #17 had a sign on the outside of the room that indicated the resident was on droplet/contact precautions and a PPE cart was outside the door that contained gowns, masks, gloves, and eye shields. Staff member #1 was observed at that time donning PPE and entered the room with the gown on backwards, tied at the neck and open in the front leaving the staff member unprotected by the gown as she entered the resident's room. An additional observation at 12:07 PM showed the gown was open in the front and clothing was exposed when the staff member opened the door to exit and removed the PPE inside the room. 2. Interview with staff member #1 on 4/10/24 at 12:07 PM confirmed the resident was on transmission-based precautions but she was not concerned about the improper donning of the gown because the resident was not symptomatic. 3. Interview with LPN #1 on 4/10/24 at 12:13 PM regarding the observation revealed the staff member needed education regarding the proper way to wear the gown before entering the room of residents in isolation. 4. Interview with the nurse manager #1 on 4/10/24 at 4:15 PM verified remedial training for donning and doffing PPE was being conducted in the facility, at that time, and it would include staff member #1. 5. Review of the facility's policy, "Standard Precautions", dated May, 2015 showed 1. Standard Precautions apply to the care of all residents regardless of their diagnosis, or suspected or confirmed infectious status .4 . <ol style="list-style-type: none"> a. Wear a gown (clean, non-sterile) to protect skin and prevent soiling of clothing during procedures and resident care activities . 		