| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 535013 | A. Building<br>B. Wing | 06/24/2025 |

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| Granite Snf Operations LLC | 3128 Boxelder Dr<br>Cheyenne, WY 82001 |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a safe and orderly discharge from the facility for 1 of 5 sample residents (#1) reviewed for discharge. The findings were:<br><br>1. Review of the 1/25/25 admission MDS assessment showed resident #1 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, non-Alzheimer's dementia, anxiety disorder, depression, and an unspecified injury of the head. The resident had a BIMS score of 3 out of 10 which indicated severe cognitive impairment. Review of the medical record showed the resident was discharged from the facility on 2/2/25. The following concerns were identified:<br><br>a. Review of a late entry note written by LPN #1, dated 2/2/25 and timed 4:55 PM, showed Resident went into another resident's room and I was behind [him/her] with that resident's pills and I asked [him/her] to get out of the room because it wasn't [his/her] room. [The resident] got angry and grabbed the tray table like [the resident] was going to shove it into [the female resident] The nurse intervened to prevent the female resident from being harmed. The note further described the resident as getting physically aggressive by stepping on the nurse's left foot to immobilize her and grabbed her throat with both of [his/her] hands. Assistance arrived at the scene and the resident was escorted to his/her room. The nurse notified the DON and called the police. The police arrived at the facility and arrested the resident for aggravated assault. Further review showed .Then one of the policeman (sic) came back up to take pictures of the facility and my neck and arm and then they asked me to print off any documentation that I had regarding [his/her] and behaviors.<br><br>b. Interview with LPN #1 on 6/24/25 at 3:52 PM revealed following the incident on 2/2/25 the police arrested the resident and handcuffed him/her as s/he left the facility. The LPN described the resident as being angry as s/he was taken away. Further, the LPN stated the police officer returned to the facility after taking the resident to jail, interviewed her, took pictures, and requested information related to the resident. The LPN stated she provided the resident's information to the police office; however, did not document what information was provided.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. Review of the 2/2/25 discharge notice addressed to the resident at the [local detention center] showed This letter will serve as formal notification that it is the intention of Granite Rehabilitation and Wellness to discharge you on February 2, 2025, as you assaulted a staff member and were arrested for aggravated assault. You are being immediately discharged for the following reasons 1. for placing the safety of the individuals in the facility in danger, 2. the health of individuals in the facility are in danger, and 3. you have not resided in the facility for 30 days. You are being discharged to the [NAME] County Detention Center .<br><br>d. Review of a social services note dated 2/2/25 and timed 6:23 PM showed ED called Son/POA [proper name] and notified him that the [local law enforcement] arrested [the resident] for aggravated assault on [LPN #1]. Also informed him that an immediate discharge notice is being given to [the resident].<br><br>e. Review of a social services note dated 2/2/25 and timed 7:39 PM showed ED drove to the [local detention center] to deliver the discharge notice to [resident name]. Was told by the deputy that they could not accept the notice tonight. Let her know that the ED would be back in the morning to provide the notice. Deputy stated that the regular business hours would be better for the jail staff.<br><br>f. Review of a social services note dated 2/3/25 and timed 10:15 AM showed ED took the discharge notice to the [local detention center] gave it to [jail staff name] at the information desk who said she would get it to [the resident]. Also sent a copy regular mail and Certified mail to [the resident]. Sent a copy regular mail and Certified mail to [resident's son/POA]. Son called ED this morning and asked if [the resident] could come back. Reminded him of our conversation last night about discharge. Again, informed him that [the resident] stepped on the nurse's foot so she couldn't move, looked at her and said, I am going to fucking kill you put both hands around her neck and tried to strangle her. [The resident] was arrested by the [local law enforcement], taken to jail and charged with aggravated assault.<br><br>2. Review of the recapitulation of resident stay, signed by the DON on 2/20/25, showed Resident discharged on 2/2/2025 after attempting to strangle a nurse while restraining her. Police were called for assistance, and the resident was arrested for aggravated assault. After arrest [nurse practitioner] was contacted regarding incident and stated that [the resident] is not safe to be in this setting and the medical group, he works for would no longer treat [the resident]. The DON was unable to provide the nurse practitioner's assessment.<br><br>3. Review of the medical record showed no evidence the facility had ensured the receiving facility could meet the needs of the resident; the appropriate information was communicated to the receiving provider; and documentation from a healthcare provider as to why the discharge was necessary.<br><br>4. Interview with the DON and ED on 6/24/25 at 3:52 PM confirmed no further documentation was available.<br><br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. Review of the Transfer and Discharge policy, published May 2002, showed .3. Transfers and discharges may occur for any of these reasons: .c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. d. The health of individuals in the facility would otherwise be endangered .4. When the facility transfers or discharges a resident under any of the above circumstances outlines (sic) in 3 (a-f), the facility documents the transfer or discharge in the medical record and appropriate information is communicated to the receiving care institution or provider. At a minimum the following information is provided: a. Contact information of the practitioner responsible for the care of the resident. b. Resident representative information, including contact information. c. Advanced Directive information. d. Special instructions or precautions for ongoing care. e. Comprehensive care plan goals. f. Other necessary information including a copy of the discharge summary. |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 1 of 3 residents (#1) reviewed for behavioral and emotional needs. This failure resulted in actual harm to resident #1 who was arrested for aggravated assault and taken to jail. The findings were:<br><br>1. Review of the 1/25/25 admission MDS assessment showed resident #1 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, non-Alzheimer's dementia, anxiety disorder, depression, and an unspecified injury of the head. The resident had a BIMS score of 3 out of 10 which indicated severe cognitive impairment, exhibited disorganized thinking which was continuously present, and did not exhibit any behaviors or rejection of care during the 7-day look-back period; however, the resident wandered daily. The resident required partial/moderate assistance with oral hygiene, toileting hygiene, showering, dressing, personal hygiene; and required supervision for eating. Further the resident required supervision to minor assistance to perform the functional abilities of rolling left and right, sitting to lying, lying to sitting, sitting to standing, transfers, and walking. The pain assessment interview showed the resident denied being in pain; however, received as needed pain medication. The resident was 67 inches tall, weighed 184 pounds, was continent of both bowel and bladder, and received an antidepressant, an antipsychotic, and an anticoagulant during the look-back period. Review of the care area assessment showed the facility was to develop a comprehensive care plan in the areas of cognitive loss/dementia, visual function, communication, urinary incontinence, behavioral symptoms, falls, nutritional status, dental care, pressure ulcer, and psychotropic drug use. Review of a 1/17/25 history and physical from the resident's provider showed the resident had diagnoses which included severe early onset Alzheimer's dementia with mood disturbance, anxiety, and a current moderate episode of major depressive disorder. The provider noted the resident was on Seroquel (an antipsychotic) and had no behaviors since arriving at the facility. A follow-up was to occur in 1 month or sooner for acute concerns. The following concerns were identified:<br><br>a. Review of the 1/13/25 hospitalist history and physical examination notes showed the resident presented to the emergency room following an episode of syncope which resulted in a fall with head trauma. The resident was administered intravenous halolperidol (antipsychotic medication used to treat mental and behavioral health conditions) due to agitation; blood work and imaging were completed and the resident was admitted to the hospital. Review of the assessment and plan showed the principal problem was syncope and collapse with an active problem of severe dementia with mood disturbance. The physician noted due to the resident's dementia with mood disturbance s/he would be started on a low dose of Seroquel at bedtime, provide PRN (as needed) halolperidol, and a 1-to-1 sitter at his/her bedside. Review of a 1/14/25 hospitalist progress note showed the resident did not sleep much .Has been up and fidgety. Has been pulling off telemetry leads, [s/he] has been redirectable but [s/he] is just constantly up and moving around. Further review showed the physician increased the dose of Seroquel to 25 mg at bedtime, and continued the PRN halolperidol and 1-to-1 sitter at bedside.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | b. Review of the 1/16/25 After Visit Summary showed a medication list which included quetiapine (antipsychotic); allopurinol (used to treat gout); atorvastatin (hypercholesterol medication); donepezil (medication to treat dementia associated with Alzheimer's disease); apixaban (an anticoagulant); fluoxetine (an antidepressant); levothyroxine (medication to treat hypothyroidism), and melatonin (used to treat insomnia). Review of a hospitalist progress note showed Patient likes to wander. Hard to redirect to be still for a prolonged period of time. Agree with not prusuing (sic) furhter (sic) testing given [his/her] dementia.<br><br>c. Review of the resident's care plan, initiated 1/23/25, showed [resident name] has a behavior problem (wandering) r/t [related to] diagnosis of dementia and nursing home adjustment. Interventions were to administer medications as ordered .anticipate and meet [resident's] needs; caregivers to provide opportunity for positive interaction, attention. Stop and talk with [him/her] as passing by .Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed . Further the care plan showed [Resident] has impaired cognitive function/dementia or impaired thought processes, impaired decision-making, long-term memory loss, short-term memory loss. Interventions were to Administer medications as ordered .Ask yes/no questions in order to determine the resident's needs .Use [resident's] preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions-turn off TV, radio, close door, etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated .Cue, reorient and supervise as needed .Keep [resident's] routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.<br><br>d. Review of the resident's care plan, initiated on 1/17/25, showed [Resident] uses antipsychotic medications (Seroquel) r/t Dementia in other diseases classified elsewhere, severe, with mood disturbance. Interventions included Administer PSYCHOTROPIC medications as ordered by physician .Monitor target behaviors: verbal aggression, irritable (sic) .Non-drug interventions: redirect. In addition, [Resident] is on sedative/hypnotic therapy (melatonin) r/t sleep disorder unspecified. Interventions included to Administer SEDATIVE/HYPNOTIC medications as ordered by physician .Monitor target behaviors: disturbed sleep pattern .Non-drug intervention: encourage good sleep hygiene and [Resident] uses antidepressant medication (fluoxetine) r/t Depression, unspecified. Interventions included Administer ANTIDEPRESSANT medications as ordered by physician .Monitor target behaviors: tearfulness, isolation .Non-drug interventions: encourage activities, encourage family friends to visit.<br><br>e. Review of the resident's care plan, revised on 1/24/25, showed [Resident] has a d/x [diagnoses] of depression, unspecified, and Generalized anxiety disorder. Interventions included to Administer medications as ordered .Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others, or thoughts of harming someone, possession of weapons or objects that could be used as weapons. There was no evidence an assessment had been completed to address the resident's wandering and behaviors or a resident-centered care plan which included non-pharmacological interventions had been developed.<br><br>f. A nurse's note dated 1/21/25 and timed 12:02 AM showed resting in bed at this time. Monitored for intrusive wandering. No attempts at exit seeking at this time .<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | g. A nurse's note dated 1/21/25 and timed 6:23 AM showed Resident is a fall risk, dementia, behaviors. Resident wanders up and down halls, often intrusively, and in [his/her] confusion will disturb others' belongings. Is cooperative and is easily redirectable. Very confused and forgetful, does not have social awareness. Has difficulty speaking when overstimulated. Unable to follow simple commands and is frequently reminded on fall precautions and call light. Has been continent, requires help finding room and BR (bathroom), but can perform ADL's (activities of daily living) with cueing.<br><br>h. A nurse's note dated 1/22/25 and timed 2:49 PM showed .Resident walks up and down halls. Touches other residents belongings. Moves chairs around. Very confused. Resident peed in the trash can today. Hard to redirect. Unable to follow simple commands. Very hard to educate, due to dementia. Educated to not pick up things off the floor. No signs or symptoms of pain.<br><br>i. A social services note dated 1/23/25 and timed 12:10 PM showed .Son reported that he wanted to come and see [the resident] and have [him/her] sign POA paperwork. SSD (social service director) discussed with son that [the resident] does not have the mental capacity to legally sign POA paperwork. SSD informed him that he would need to pursue guardianship .<br><br>j. A nurse's note dated 1/24/25 and timed 5:30 PM showed Resident kept coming through the nurses station and [s/he] was asked not to on several occasions so when this nurse stood up and asked [him/her] to please turn around, [s/he] grabbed my R arm and shoved me out of the way. This nurse called for help from the CNA to assist in redirection.<br><br>k. A nurse's note dated 1/25/25 and timed 10:59 PM showed [Resident] has been wandering and more restless than usual this evening. Had visit from [his/her] sons this evening that seems to have left [him/her] wound up a bit. More difficult to redirect this evening, and a bit more on edge when answering questions, slightly becoming verbally aggressive.<br><br>l. A nurse's note dated 1/26/25 and timed 2:37 PM showed .resident walks up and down halls. Touches other residents belongings and goes behind the nurses desk and gets into stuff. Moves chairs around. Very confused. Unable to follow simple commands. Needs cueing all the time. Very hard to educate, due to dementia. Educated to not pick up things off the floor. Educated on not going into other residents rooms. No signs or symptoms of pain. Continues to work with PT (physical therapy).<br><br>m. A nurse's note dated 1/28/25 and timed 11:12 AM showed Resident has been trying to help [resident room number] stand up and pulling [female resident]. [The resident] was also noted to be rubbing [female resident's] legs this morning . The resident was redirected and educated not to touch other residents.<br><br>n. A nurse's note dated 1/29/25 and timed 12:24 PM showed Resident was walking around dining room with fork and butter knife. When this nurse approached and asked if I could hold those for [him/her] and show [him/her] where to sit [the resident] hit my R index finger with the butter knife and left red indentation. No break in skin. CNA came to help redirect Resident to table and took [his/her] silverware until meal time.<br><br>o. A nurse's note dated 1/30/25 and timed 4:11 PM showed [Provider name] contacted regarding increase in physically aggressive behaviors towards staff and increased intrusive wandering. Order received for PRN Seroquel 25 mg every 6 hours for 1 day as [provider name] will see resident and evaluate change in behaviors further .<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | p. A nurse's note dated 1/30/25 and timed 5:13 PM showed Resident noted to be urinating on fake plant, resident educated that this is not appropriate behavior, resident told this nurse to fuck off. Will continue to monitor.<br><br>q. A nurse's note dated 1/30/25 and timed 5:37 PM showed [Provider name] was here this afternoon and notified of resident going into rooms and getting into residents beds, by a resident. Review of the resident's medical record showed no evidence of this provider visit. Interview with the DON on 6/24/25 at 1:27 PM confirmed the progress note was not in the resident's record; however, was able to retrieve it from the provider's electronic medical record system.<br><br>r. A nurse's note dated 1/31/25 and timed 8:24 PM showed [Res] generally confused and disoriented, requiring very frequent redirection. Res did show some aggression toward this nurse immediately after [his/her] blood was drawn, making a mean face and mumbling while trying to kick toward me and shaking [his/her] fist. Res reassured and given space, now resting in bed.<br><br>s. A nurse's note dated 2/1/25 and timed 2:34 PM showed [Resident] is getting agitated this afternoon after having a calm morning. [S/he] is following very closely behind people in the hallway, going into rooms, getting in personal space, messing with things on the counters and carts, trying to get into the elevator and getting upset with redirection.<br><br>t. A nurse's note dated 2/2/25 and timed 10:51 AM showed We have noticed that [the resident] is cooperative in the am, but as the day goes on [s/he] starts to get more agitated and less cooperative. Appears to sundown. [The resident] does not take [his/her] evening meds well as we often have to switch nurses to try to give them .<br><br>u. A nurse's note dated 2/2/25 and timed 11:58 AM showed .[resident] likes to follow females (staff and residents) down the hall at a close distance. [S/he] also likes to hide in the cubbies at the end of the hallways and needs redirection back to the dining room.<br><br>v. A nurse's note dated 2/2/25 and timed 1:40 PM showed CNA reported that Resident walked down hallway and was attempting to go into another resident's room and upon redirection, Resident called CNA a fucking bitch.<br><br>w. A late entry nurse's note written by LPN #2, dated 2/2/25 at 4:55 PM, showed Resident went into another resident's room and I was behind [him/her] with that resident's pills and I asked [him/her] to get out of the room because it wasn't [his/her] room. [The resident] got angry and grabbed the tray table like [the resident] was going to shove it into [the female resident] The nurse intervened to prevent the female resident from being harmed. The note further described the resident as getting physically aggressive by stepping on the nurse's left foot to immobilize her and grabbed her throat with both of [his/her] hands. Assistance arrived at the scene and the resident was escorted to his/her room. The nurse notified the DON and called the police. The police arrived at the facility and arrested the resident for aggravated assault.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2. Review of a 1/31/25 skilled nursing progress note from the resident's provider (retrieved from the provider's electronic medical record by the DON) showed the chief complaint was the resident had been urinating in and on the plants around the unit and crawling into the beds of female residents on the unit. The assessment and plan showed Due to increase in behaviors and sexual tendencies, will increase Prozac from 10 to 30 mg daily. Increase seroquel to BID (twice a day). Monitor for medication effectiveness and any worsening of behaviors. A follow-up was to occur in 1 month or sooner for acute concerns. There was no evidence a behavioral care plan had been developed.<br><br>3. Interview with the social service director on 6/24/25 at 1:01 PM revealed the resident had severe dementia; was confrontational; would wander in and out of other resident's rooms; was not easily de-escalated; and required a lot of redirection. Further, the social service director stated the facility was hesitant about placing the resident in the secure unit because the resident would not do well behind locked doors. Documentation was requested from the social service director related to what interventions were attempted; however, no documentation was received.<br><br>4. Interview with the DON on 6/24/25 at 1:27 PM revealed the resident exhibited both verbal and physical aggressive behaviors from the beginning and had a history of alcohol abuse and polysubstance abuse. The DON stated the resident was difficult to redirect and she thought the resident purposefully repeated some behaviors. Further the DON stated residents requesting admission to the facility were evaluated by the admissions department and were determined to be green which was to admit; yellow which required more review, and red was denied. The DON was not aware of what color the resident's review was; however, the facility required 48 hours without a 1-to-1 sitter and without chemical intervention before the resident could be admitted .<br><br>5. Interview with LPN #1 on 6/24/25 at 3:52 PM revealed upon admission the resident wandered the halls; needed to be busy; and an intervention was to redirect and offer the resident an activity. In addition, the LPN stated she talked to the resident's providers daily; however, confirmed she had failed to chart the conversations. The LPN stated following the incident on 2/2/25 the police arrested the resident and handcuffed him/her before being escorted out of the facility. The LPN described the resident as being angry as s/he was taken away.<br><br>6. Interview with the ED on 6/24/25 at 3:52 PM revealed she thought the facility was misled by the resident's referral documentation as they thought the resident was nonverbal. In addition, the ED stated many of the residents that come from the hospital have notes related to 1-to-1 sitters and the use of chemical interventions for behaviors and there was nothing in the resident's history to indicate s/he could be violent.<br><br>7. Interview with the DON on 6/24/25 at 3:52 PM revealed the facility determined the secure unit would increase the resident's agitation due to the locked doors and therefore was placed where the resident was not as restricted. |