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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 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 .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 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 .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50665 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. 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 [DATE] 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. 35081

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 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 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 .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 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 .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50665 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 [DATE] at 4:44 PM showed a box of Bisacodyl (laxative) suppositories with an expiration date of ,d+[DATE]. 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 [DATE] 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 ,d+[DATE] 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 .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 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 [NAME]/[NAME] 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 .