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	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Rehabilitation and Wellness	3128 Boxelder Dr 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident, resident representative, and staff interview, facility incident review, and policy and procedure review, the facility failed to ensure residents' environment was free of accident hazards on 3 of 4 resident care units (1st floor, 2nd floor, 3rd floor) reviewed for safe water temperatures and for 2 of 3 sample residents (#5, #97) reviewed for falls. The facility implemented a plan of correction regarding the fall during van transport for resident #5, prior to the survey, and verified during the survey. The facility was determined to be in compliance for the fall during van transport on 3/11/26. The findings were: Related to resident falls: 1. Review of a quarterly MDS assessment dated [DATE] showed resident #97 had a BIMS score of 6 out of 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and depression. The following concerns were identified: a. Review of an incident report dated 1/1/26 and timed 4:15 PM showed Resident was outside ambulating per careplan, when visitor witnessed resident trip and fall and immediately called into facility and notified facility that resident had fallen. LPN [#1] responded and completed vital signs, resident became agitated wanting to stand up and nurse and CNA assisted resident to stand up, resident regained balance quickly after staff assisted to stand. The incident review showed Immediate Action Taken was Resident assisted to standing position and times two nurses came into building. Assessed resident. Noted heavy bleeding from upper left eye of face. 911 called immediately. Notified on call and DNS and FNP [name] resident going to [hospital] for treatment and follow up. Laceration above left eye noted by EMS to have rock in skin. Resident has history of Alzheimer's. Notified family [name] R/P of fall. Resident had some grimacing noted. Neuro checks to be initiated upon return. Orders in order set. Further review showed Predisposing Physiological Factors was marked for confused. b. Review of a progress note dated 1/1/26 and timed 5:38 PM showed .Alert Charting: Skin Issue (New/Worsened/Change) Acute s/s [signs and symptoms], tachycardia, fever, chills, n/v [nausea vomiting], wound drainage, pain, mentation, Interventions, outcomes, Vitals: [NAME] by notified staff resident had fall outside. Resident had noted bleeding to left upper eye. Laceration noted. Resident sent to [hospital] at present for evaluation via stretcher . c. Review of an elopement risk assessment dated [DATE] showed the resident had a history of wandering, had medical diagnosis of dementia/cognitive impairment, and had diagnosis impacting gait/mobility or strength. Further review showed the resident was not at risk for elopement due to s/he understands sign out policy. d. Interview with the resident's representative on 3/26/26 at 12:13 PM revealed prior to the resident's (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	fall s/he seemed to be alert; however, s/he had a monitor on him/her and was not supposed to go outside without supervision. The representative revealed when the resident fell, the representative was notified by the facility and was told a visitor had put in the code and let the resident out. Further interview revealed the resident passed away on 1/6/26. e. Review of an Order Audit Report dated 3/26/26 showed a wandergard bracelet was ordered on 2/28/25 and discontinued on 3/12/25. f. Interview with LPN #1 and the DON on 3/26/26 at 11:53 AM revealed the resident ambulated with a walker and liked to go for walks at times. The LPN indicated the resident was alert and oriented to person and place, would go outside for 15 minutes, and was free to come and go. The LPN revealed on the day the resident fell outside, s/he had notified the DON prior. The LPN revealed a visitor notified the facility the resident had a fall by calling the building and letting them know. The LPN revealed she came down stairs, helped the resident up, and assisted the resident inside. The LPN confirmed the resident had a laceration on his/her face and she called the ambulance. The LPN revealed the resident returned from the hospital and later went on hospice due to a brain tumor. The DON indicated the resident's low BIMS score was due to him/her not wanting to answer questions for the exam. Further the DON revealed the facility had an assessment indicating the resident was safe to walk outside independently. g. Interview with LPN #2 on 3/26/26 at 12:06 PM confirmed she was the other nurse working on the day of the resident's fall. She revealed the resident was alert and oriented times 3 or 4 with his/her confusion usually being related to time. She confirmed the facility was notified of the resident's fall via phone call from someone who was driving by. She revealed she and LPN #1 went downstairs and found the resident outside with a gash on his/her forehead. She confirmed the resident was assisted inside, cleaned up, and sent to the hospital. 2. Review of a significant change MDS assessment dated [DATE] showed resident #5 had a BIMS score of 12 out 15, which indicated the resident was cognitively intact, and diagnoses which included other fusion of the spine, repeated falls, and pain. Further review showed the resident had upper and lower extremity impairment on one side, used a wheelchair, and was dependent on staff for transfers. The following concerns were identified: a. Interview with the resident on 3/24/26 at 9:20 AM revealed recently s/he had a fall from his/her wheelchair while riding in the facility van. The resident revealed the social worker was driving and s/he thought they had hit a vehicle in front of them or the driver hit the brakes hard, which resulted in him/her sliding out of his/her wheelchair and landing between the two front seats. The resident revealed at the time of the incident, s/he was not properly secured in the wheelchair. b. Review of an incident report dated 3/4/26 and timed 4:45 PM showed the resident was picked up at the hospital by social services staff member #1. The resident was positioned in his/her wheelchair with a full body lift sling underneath him/her. The incident report showed while driving the resident back to the facility, a vehicle in front of the van stopped abruptly causing the social services staff member to abruptly stop as well and the resident slid forward in his/her wheelchair. The incident report showed the social services staff member pulled over to assist the resident and after evaluating the resident's position, assisted the resident to the van floor in a controlled fashion. The incident report showed after assisting the resident to the floor, the social services staff member provided standby support to assist the resident back into the wheelchair. Further review showed the social services staff member continued to the facility where the resident was assessed upon arrival. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	c. Interview with social services staff member #1 on 3/25/26 at 3:44 PM revealed he picked the resident up from the hospital because s/he had been taken to the emergency room. He revealed while they were driving back to the facility, a vehicle in front of them slammed on the brakes and he told the resident to hold on. He revealed when he hit the brakes, the resident slid out of his/her wheelchair. He revealed he pulled up a little and found a safe place to pull over. He revealed when he pulled over, the resident was positioned on the wheelchair leg rest with his/her back pressed against the wheelchair. The social services staff member revealed he thought the resident fell because the seatbelt catch did not function correctly. He revealed he physically assisted the resident back into the wheelchair, started to head back to the facility, and contacted the administrator on the way. d. Observation on 3/26/26 at 8:09 AM showed the facility van had 4 securement straps which were affixed to the floor of the van and each strap had a hook on the end that attached over the wheelchair frame. Each strap applied a constant pulling pressure to ensure securement. The observation showed the seat belt with a shoulder harness which was used was a common shoulder type seatbelt. Further observation showed the seatbelt could be lengthened and retracted without restriction, and would not prevent movement in the wheelchair. Interview with the social services director at that time confirmed the seatbelt with a should strap which was used in the van was the traditional style. Further interview revealed there was a strap that secured to the mounting bracket of the seatbelt with a shoulder strap and the mounting bracket of the rear floor securement which prevent movement when it was secured; however, he confirmed the additional strap was not in use at the time of the incident. e. Interview with a facility vendor on 3/26/26 at 12:42 PM revealed the facility's van was assessed on 3/4/26 following an incident and assessed a second time following another incident the same day. The vendor revealed the second incident was the result of a seatbelt failure and parts were ordered to fix it; however, it would take time for the seatbelt parts to arrive. f. Review of an action plan for Van Incident #2 last updated on 3/18/26 showed the van was taken in to vendor to verify seat belt function on 3/4/26 and a decision was made to remove the van from service until new seatbelts were purchased and installed. Observations to verify the van was not in use for transport was performed during the survey. Additionally, the facility implemented van driver education and audits for resident securement which were verified during the survey. The plan was determined to be fully implemented and the facility was in substantial compliance with wheelchair securement during transport on 3/11/26. Related to safe water temperatures 1. Observation on 3/26/26 at 10:12 AM showed the first floor shower room reached a maximum temperature 130.5 degrees F during a 5 minute continuous monitor of water flow which was verified by the maintenance assistant. 2. Observation on 3/26/26 at 1:15 PM showed the second floor shower room reached a maximum temperature 125.1 degrees F during a 5 minute continuous monitor of water flow which was verified by the maintenance assistant. 3. Interview with the maintenance assistant on 3/26/26 at 1:38 PM revealed the maximum water temperature reading exceeded 110 degrees F in 11 resident rooms' bathroom sinks when he checked during a continuous water flow for 7 to 10 minutes. In room [ROOM NUMBER] the temperature was 134.4 degrees F, in room [ROOM NUMBER] the temperature was 129.5 degrees F, in room [ROOM (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	NUMBER] the temperature was 129 degrees F, in room [ROOM NUMBER] the temperature was 125.2 degrees F, in room [ROOM NUMBER] the temperature was 115.3 degrees F, in room [ROOM NUMBER] the temperature was 135.1 degrees F, if room [ROOM NUMBER] the temperature was 137.6 degrees F, in room [ROOM NUMBER] the temperature was 143.2 degrees F, in room [ROOM NUMBER] the temperature was 133.3 degrees F, in room [ROOM NUMBER] the temperature was 140.5 degrees F, and in room [ROOM NUMBER] the temperature was 128.9 degrees F. Further interview revealed the facility shut off the water and contracted a plumber during the high water temperature evaluation to correct the excessive temperatures.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to ensure adequate interventions and monitoring were provided to prevent significant weight loss and resulting harm for 2 of 8 sample residents (#2, #10) reviewed for nutrition, and offer sufficient fluid intake for 1 of 4 units (secure unit) reviewed for hydration. The findings were: Related to adequate nutrition interventions and monitoring 1. Review of the admission MDS dated [DATE] showed resident #2 had a BIMS score of 8 out of 15 which indicated moderate cognitive impairment, diagnoses which included cerebrovascular accident (CVA) and malnutrition, and required partial to moderate assistance with eating once the meal was placed before the resident. Review of the admission care plan dated 2/2025 and last revised on 2/25/26 showed the resident required meal setup with assisting and cueing for meals. The following concerns were identified: a. Observation on 3/24/26 at 12:54 PM showed resident #2 had a meal tray on his/her bedside table. The resident was asleep, and there were no staff at the bedside to assist with the meal. b. Observation on 3/25/26 at 6:09 PM showed staff delivered a meal tray and woke resident #2 up to eat. The resident stated oh it's dinner time, the tray was left at his/her bedside by staff, and the staff left the room. Continued observation at 6:43 PM showed activity staff #1 warmed the resident's tray and assisted the resident with eating. c. Review of the medical record showed resident #2 weighed 173 pounds on 2/2/26 and 159.9 pounds on 3/9/26, which indicated a 7.57% weight loss in less than 3 months. Further review showed a nutrition evaluations had been completed on 2/23/26 and 3/20/26 which indicated the resident required meal set-up and assist with cueing for eating. d. Review of the facility policy titled Weights dated 7/30/24 showed 1.a. New admits: Weigh the day of admission then weekly for one month; If the weights and nutritional status are stable after one month, weigh the resident monthly. There was no evidence resident #2 was weighed more than twice in the first month of admission. 2. Review of the significant change MDS dated [DATE] showed resident #10 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, diagnoses which included Alzheimer's disease, weakness, and malnutrition, and s/he required partial to moderate assistance with eating once the meal was placed before the resident. Review of the care plan dated 2/11/26 and last revised 2/25/26 showed the resident required partial to moderate assistance by 1 staff with eating meals. The following concerns were identified: a. Observation on 3/25/26 at 5:48 PM showed 2 CNAs woke resident #10 for dinner, s/he went back to sleep, and they did not stay to assist him/her with eating dinner. b. Observation on 3/26/26 at 8:33 AM showed resident #10 had a meal tray at his/her bedside, and no staff assisted with the meal. Meal trays were being delivered to other residents after resident's meal was delivered. c. Review of the medical record showed resident #10 weighed 188 pounds on 1/1/26 and 169 pounds (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	on 2/1/26, which indicated a 10.11% weight loss in one month. Further review of the medical record showed a nutrition evaluation for weight loss dated 2/6/26 showed the resident required meal set up and assist as needed for eating. d. Review of the facility policy titled Weights dated 7/30/24 showed 1.b. Weekly Weights: The following are guidelines for residents who may need to be weighed weekly (not all inclusive) . significant weight loss/gain defined by 5% loss in 30 days. Resident #10 was weighed on 2/1/26 and there was no evidence that they were weighed again until 2/13/26. 3. Interview with the regional dietitian on 3/26/26 at 11:57 AM revealed she received monthly weight loss reports from the facility. She or her staff spoke with nursing staff to obtain additional pertinent information for each residents' possible weight change, and interventions were planned accordingly. The nursing staff was responsible to notify residents' families of changes. 4. Interview with LPN #3 on 3/26/26 at 12:13 PM revealed residents who required assist from one person for meals received their trays last, and the staff who delivered the tray should immediately assist the resident. 5. Interview with CNA #1 on 3/26/26 at 12:17 PM revealed residents who were able to eat in their room independently received their trays first. Residents who ate in the dining area were served second, residents who required assistance with meals were served last, and the staff who delivered the tray was to assist the resident with their meal. 6. Interview with the DON on 3/26/26 at 12:20 PM revealed her expectation for meal assisted trays was that they were served last, and the staff who delivered the tray assisted the resident with their meal. 7. Review of facility policy titled Weights dated 7/30/24 showed 1.a. New admits: Weigh the day of admission then weekly for one month; If the weights and nutritional status are stable after one month, weigh the resident monthly; 1.b. Weekly Weights: The following are guidelines for residents who may need to be weighed weekly (not all inclusive) . significant weight loss/gain defined by 5% loss in 30 days. Related to sufficient fluid intake 1. Observations on 3/25/26 starting at 3:25 PM showed the residents in the secure unit were seated at tables in the dayroom. No drinks were offered to residents throughout extended observation from 3:25 to 5:41 PM. 2. Interview with CNA #2 on 3/23/25 at 5:35 PM revealed drinks were not stored in the unit refrigerator, and the residents were served drinks at mealtime only. Further interview revealed there was a hydration station on the 3rd floor unit, however she was unable to leave the secure unit to obtain drinks because often she was the only aide on the unit. 3. Interview with LPN #2 on 3/23/25 at 5:37 PM revealed the residents received drinks at each meal. 4. Interview with CNA #2 on 3/25/26 at 3:55 PM revealed some residents had water at their bedside, but others were unable to because they spilled it. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	5. Interview with the FANS Manager #2 on 3/25/26 at 6:36 PM revealed drinks were kept at the hydration station on the 3rd floor outside of the locked unit, and the nurse kept a pitcher of water on the cart to use when they passed medications. She reported she had ordered containers similar to the ones kept on the other units hydration stations but they did not fit under the cabinets on the secure unit. She stated the staff had been told they could not keep pitchers of drinks on the unit because several residents had touched the pitchers. She stated her expectation was for fluids to be offered every hour, and she confirmed routine fluids were not being offered.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and resident and staff interview, the facility failed to provide the residents with a comfortable and homelike environment in 3 of 3 showering areas. The findings were:1. Interview with Resident #71 on 3/23/26 at 3:09 PM revealed .the temperature of the showers are usually cold and sometimes it will fluctuate from cold to super hot and back to cold during the entire shower.2. Interview with resident #55 on 3/24/26 at 3:06 PM during resident council revealed the temperature in the second floor shower room was too cold or too steamy.3. Observation on 3/26/26 at 9:40 AM showed the second floor shower room water temperatures fluctuated consistently between 68.3 degrees Fahrenheit (F) to 102.6 degrees F during a 5 minute continuous flow of water which was verified by the maintenance assistant.4. Interview with the maintenance assistant on 3/26/26 at 9:50 AM confirmed the residents complained about the fluctuating temperatures in the second floor shower room. He revealed residents were often taken to another floor for showers. 5. Observation on 3/26/26 at 10:12 AM showed the first floor shower room water temperatures fluctuated consistently between 107.2 degrees F to 130.5 degrees F during a 5 minute continuous flow of water which was verified by the maintenance assistant. 6. Observation on 3/26/26 at 10:57 AM showed the third floor shower room water temperatures fluctuated consistently between 70.9 degrees F to 92.2 degrees F during a 5 minute continuous flow of water which was verified by the maintenance assistant.7. Observation on 3/26/26 at 1:15 PM the facility requested a recheck in second floor shower room that showed the water temperatures fluctuated consistently between 82 degrees F to 125.1 degrees F during a 5 minute continuous flow of water which was verified by the maintenance assistant.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interview, facility incident review, and standard of practice review, the facility failed to ensure treatment and care was provided to 1 of 4 sample residents (#5) reviewed for falls. The findings were:1. Review of a significant change MDS assessment dated [DATE] showed resident #5 had a BIMS score of 12 out 15, which indicated the resident was cognitively intact, and diagnoses which included other fusion of the spine, repeated falls, and pain. Further review showed the resident had upper and lower extremity impairment on one side, used a wheelchair, and was dependent on staff for transfers. The following concerns were identified:a. Interview with the resident on 3/24/26 at 9:20 AM revealed recently s/he had a fall from his/her wheelchair while riding in the facility van. The resident revealed the social worker was driving and s/he thought they had hit a vehicle in front of them or the driver hit the brakes hard, which resulted in him/her sliding out of his/her wheelchair and landing between the two front seats. The resident revealed at the time of the incident, s/he was not properly secured in the wheelchair.b. Review of an incident report dated 3/4/26 and timed 4:45 PM showed the resident was picked up at the hospital by social services staff member #1. The resident was positioned in his/her wheelchair with a full body lift sling underneath him/her. The incident report showed while driving the resident back to the facility, a vehicle in front of the van stopped abruptly causing the social services staff member to abruptly stop as well and the resident slid forward in his/her wheelchair. The incident report showed the social services staff member pulled over to assist the resident and after evaluating the resident's position, assisted the resident to the van floor in a controlled fashion. The incident report showed after assisting the resident to the floor, the social services staff member provided standby support to assist the resident back into the wheelchair. Further review showed the social services staff member continued to the facility where the resident was assessed upon arrival.c. Interview with social services staff member #1 on 3/25/26 at 3:44 PM revealed he picked the resident up from the hospital because s/he had been taken to the emergency room. He revealed while they were driving back to the facility, a vehicle in front of them slammed on the brakes and he told the resident to hold on. He revealed when he hit the brakes, the resident slid out of his/her wheelchair. He revealed he pulled up a little and found a safe place to pull over. He revealed when he pulled over, the resident was positioned on the wheelchair leg rest with his/her back pressed against the wheelchair. The social services staff member revealed he thought the resident fell because the seatbelt catch did not function correctly. He revealed he physically assisted the resident back into the wheelchair, started to head back to the facility, and contacted the administrator on the way. Further interview revealed the social services staff member did not have a nursing background and confirmed the resident was not assessed until the van returned to the facility. 2. Interview with the DON on 3/26/26 at 1:05 PM revealed residents should be assessed prior to moving residents following a fall and confirmed social services staff member #1 did not have training to assess or physically assist with transfers of a resident. 3. Review of Wolters Kluwer's Lippincott Nursing Procedures Ninth Edition, copyright 2023, page 1780, showed .Nursing Alert Don't move the patient until you fully evaluate the patient's status to prevent further injury if an injury has occurred as result of the fall .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to ensure outdated food was disposed of in 1 of 1 kitchen. 1. Observation on 3/23/26 at 2:05 PM in the main kitchen showed there were 5 sealed cups of thickened orange juice that had a best-buy date of 11/8/25 in the refrigerator used for the storage of drinks that were provided to residents. 2. Observation on 3/23/26 at 2:09 PM showed the FANS Manager #2 threw away a case of thickened orange juice cups that had been stored in the dry storage room. 3. Interview with the FANS manager #1 on 3/23/36 at 2:05 PM revealed all drinks in the refrigerator were for resident use, and resident #27 received thickened liquids. Further interview confirmed the juices were outdated, and the juice cups should not be served to residents. 4. Review of the facility policy titled Food Storage last updated 10/2017 showed .11. The manufacturer's expiration date, when available, is the use by date for unopened items .