

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/26/2026 |
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| NAME OF PROVIDER OR SUPPLIER Granite Rehabilitation and Wellness | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3128 Boxelder Dr , Cheyenne, Wyoming, 82001 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F0000 | INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/23/26 through 3/26/26. Also reviewed in the course of the survey were complaint intakes 2710174, 2716723, 2793540, and 2806231. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing DNS: Director of Nursing Services FANS: Food and Nutrition Services FNP: Family Nurse Practitioner LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency. | F0000 | | 04/09/2026 |
| F0689 SS = G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate | F0689 | Free of accident hazards/supervision/devices F 689 Corrective Action Resident #97 discharged on 1/6/2026. Install and/or calibrate thermostatic mixing valves to validate consistent delivery of safe water temperatures 4/24/26. IDENTIFICATION OF OTHERS | 05/08/2026 |

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 reverse for further 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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0689 SS = G | <p>Continued from page 1 supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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:</p> <p>Related to resident falls:</p> <p>1. Review of a quarterly MDS assessment dated 11/10/25 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:</p> <p>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."</p> <p>b. Review of a progress note dated 1/1/26 and timed</p> | F0689 | <p>Continued from page 1</p> <p>Residents who experienced falls ambulating outside of facility without supervision in last 30 days reevaluated 4/10/2026 for the ability to safely ambulate outside without supervision. Risk vs Benefit was completed with resident/responsible party of resident who ambulate outside without supervision.</p> <p>Residents who use the shower for bathing and hand sinks have the potential to be affected by this practice.</p> <p>SYSTEMIC CHANGE</p> <p>Staff education completed by 4/14/2026 by the DON/designee regarding completion of Morse Fall Scale for the residents who ambulate outside independently upon admission, quarterly and with change in condition for safety.</p> <p>Residents are evaluated for the ability to ambulate outside independently upon admission, quarterly and with a change in condition using the MORSE Fall Scale.</p> <p>The Maintenance Director/designee records the temperatures of each shower room and random resident rooms twice daily to validate consistent delivery of safe water temperatures. Should a temperature be identified as outside the safe range it is addressed by the Maintenance Team.</p> <p>The Maintenance Team was provided in-service training by the administrator related to safe water temperatures for both showers and resident room water.</p> <p>The staff received in-service training from the administrator related validating comfortable water temperatures prior to a shower.</p> <p>MONITORING</p> <p>The DON reviews falls for falls outside 5 times per week and validates that appropriate interventions are in place. The results of this review are reported to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.</p> <p>The Maintenance Director monitors the water temperatures to verify that temperatures are within</p> | 05/08/2026 |

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| F0689 SS = G | <p>Continued from page 2 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: Passerby 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..."</p> <p>c. Review of an elopement risk assessment dated 4/1/25 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."</p> <p>d. Interview with the resident's representative on 3/26/26 at 12:13 PM revealed prior to the resident's 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.</p> <p>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.</p> <p>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.</p> <p>g. Interview with LPN #2 on 3/26/26 at 12:06 PM</p> | F0689 | Continued from page 2 safe range and reports any negative patterns or trends to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue. | 05/08/2026 |

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| F0689 SS = G | <p>Continued from page 3 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.</p> <p>2. Review of a significant change MDS assessment dated 3/3/26 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:</p> <p>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.</p> <p>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.</p> <p>c. Interview with social services staff member #1 on</p> | F0689 | | 05/08/2026 |

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| F0689 SS = G | <p>Continued from page 4</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> | F0689 | | 05/08/2026 |

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| F0689 SS = G | <p>Continued from page 5</p> <p>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.</p> <p>Related to safe water temperatures</p> <p>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.</p> <p>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.</p> <p>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 303 the temperature was 134.4 degrees F, in room 304 the temperature was 129.5 degrees F, in room 307 the temperature was 129 degrees F, in room 308 the temperature was 125.2 degrees F, in room 311 the temperature was 115.3 degrees F, in room 312 the temperature was 135.1 degrees F, in room 316 the temperature was 137.6 degrees F, in room 317 the temperature was 143.2 degrees F, in room 320 the temperature was 133.3 degrees F, in room 321 the temperature was 140.5 degrees F, and in room 325 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.</p> | F0689 | | 05/08/2026 |
| F0692 SS = G | <p>Nutrition/Hydration Status Maintenance</p> <p>CFR(s): 483.25(g)(1)-(3)</p> <p>§483.25(g) Assisted nutrition and hydration.</p> <p>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(1) Maintains acceptable parameters of</p> | F0692 | <p>Posted</p> <p>Person, Kaylee</p> <p>F 692</p> <p>Nutrition/Hydration Status Maintenance</p> <p>CORRECTIVE ACTION</p> <p>Resident #2 Kardex and Tray Card corrected on 4/8/2026 to reflect appropriate level of care required at meals.</p> | 05/08/2026 |

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| F0692 SS = G | <p>Continued from page 6 nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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:</p> <p>Related to adequate nutrition interventions and monitoring</p> <p>1. Review of the admission MDS dated 2/9/26 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:</p> <p>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.</p> <p>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.</p> <p>c. Review of the medical record showed resident #2 weighed 173 pounds on 2/2/26 and 159.9 pounds on</p> | F0692 | <p>Continued from page 6</p> <p>Resident #10 discharged from facility on 4/8/2026.</p> <p>Hydration Station placed in dementia unit 3/26/2026 for ease of access to fluids.</p> <p>IDENTIFICATION OF OTHERS</p> <p>The DON reviewed the residents in facility for level of assist needed at meals on 4/10/26. Any resident identified as needing assistance had the Kardex and Tray Card updated to reflect the assistance identified.</p> <p>Residents admitted during the last 30 were audited to verify that weights had been conducted according to policy. Any identified as not being weighed on admission per policy had weekly weights restarted.</p> <p>Residents who reside on the dementia unit have a potential to be at risk due to this practice.</p> <p>SYSTEMIC CHANGE</p> <p>Residents are assessed based on hospital recommendation on admission and using the Functional Abilities on change of condition to determine if any assistance is needed with eating. This is then added to the Kardex and Tray Card in order to be available to the staff. Meal monitors randomly spot check residents requiring assistance to validate assistance is being provided.</p> <p>Staff were educated by 4/13/2026 related to ensuring residents are provided with appropriate level of assistance at meals and to find the level of assistance on the Kardex and Tray Card.</p> <p>Residents are weighed on admission according to policy.</p> <p>The nursing staff was provided in-service education on 4/13/26 relate to weighing newly admitted residents weekly for 4 weeks according to the weight policy.</p> <p>A hydration station was provided to the dementia unit for easy access to fluids on 3/26/26.</p> <p>Staff was provided in-service education by the DON/designee related to frequent offers of fluids throughout the day.</p> <p>Dietary staff was provided education on 3/27/26 by the dietary manager to fill, check and clean the hydration stations daily.</p> | 05/08/2026 |

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| F0692 SS = G | <p>Continued from page 7 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.</p> <p>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.</p> <p>2. Review of the significant change MDS dated 2/9/26 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:</p> <p>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.</p> <p>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.</p> <p>c. Review of the medical record showed resident #10 weighed 188 pounds on 1/1/26 and 169 pounds 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.</p> <p>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.</p> <p>3. Interview with the regional dietitian on 3/26/26 at 11:57 AM revealed she received monthly weight loss</p> | F0692 | <p>Continued from page 7</p> <p>MONITORING</p> <p>The DON/designee audits diners requiring assist 5 times per week and validates that appropriate level of assistance is on the Kardex and Tray Card. The results of this review are reported to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue</p> <p>The DON reviews the admission weights 5 times per week and validates that appropriate care planning is in place. The results of this review are reported to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.</p> <p>The Dietary manager/designee will audit placement of hydration station 5x per week. The results of this review are reported to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.</p> | 05/08/2026 |

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| F0692 SS = G | <p>Continued from page 8 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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...".</p> <p>Related to sufficient fluid intake</p> <p>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.</p> <p>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.</p> <p>3. Interview with LPN #2 on 3/23/25 at 5:37 PM</p> | F0692 | | 05/08/2026 |

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| F0692 SS = G | Continued from page 9 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. 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. | F0692 | | 05/08/2026 |
| F0584 SS = E | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; | F0584 | Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. Safe Clean Comfortable Homelike F 584 CORRECTIVE ACTION Install and/or calibrate thermostatic mixing valves to validate consistent delivery of safe water temperatures 4/24/26. IDENTIFICATION OF OTHERS Residents who use the shower for bathing and hand sinks have the potential to be affected by this practice. SYSTEMIC CHANGE The Maintenance Director/designee records the temperatures of each shower room and random resident rooms twice daily to validate consistent delivery of safe water temperatures. Should a | 05/08/2026 |

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| F0584 SS = E | Continued from page 10 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: 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. | F0584 | Continued from page 10 temperature be identified as outside the safe range it is addressed by the Maintenance Team. The Maintenance Team was provided in-service training by the administrator related to safe water temperatures for both showers and resident room water. The staff received in-service training from the administrator related validating comfortable water temperatures prior to a shower. MONITORING The Maintenance Director monitors the water temperatures to verify that temperatures are within safe range and reports any negative patterns or trends to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue. | 05/08/2026 |

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| F0584 SS = E | Continued from page 11 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. | F0584 | | 05/08/2026 |
| F0684 SS = D | Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 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 3/3/26 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 | F0684 | F 684 Quality of Care CORRECTIVE ACTION Resident #5 was assessed by RN upon return to facility on 3/4/2026 IDENTIFICATION OF OTHERS Records of residents who have had a fall in the last 30 days were audited for licensed nurse assessment on 4/10/2026. Audit revealed all falls had assessment at time of fall prior to moving with 1 exception. Resident was assessed upon return to facility as he/she was out with family at the time of the fall. No injury. SYSTEMIC CHANGE Staff education completed by 4/14/2026 regarding appropriate assessment at time of resident falls prior to the resident being moved by licensed personnel and that only licensed personnel can move residents. Staff education also completed that when a fall occurs off facility property and a nurse is not available to call EMS and not to move resident. DON/designee monitors the resident falls to verify that a licensed nurse has assessed the resident for injuries prior to movement. Any identified fall without a licensed nursing assessment will be addressed with the appropriate staff member. MONITORING The DON reviews the falls 5 times per week and validates that assessment has been completed by a licensed nurse. The results of this review are reported to the Quality Assurance Performance Improvement Committee monthly for their review and | 05/08/2026 |

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| F0684 SS = D | <p>Continued from page 12 properly secured in the wheelchair.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>3. Review of Wolters Kluwer's "Lippincott Nursing</p> | F0684 | Continued from page 12 resolution. These audits will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue. | 05/08/2026 |

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| F0684 SS = D | Continued from page 13 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..." | F0684 | | 05/08/2026 |
| F0812 SS = D | <p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure outdated food was disposed of in 1 of 1 kitchen.</p> <p>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.</p> <p>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.</p> <p>3. Interview with the FANS manager #1 on 3/23/36</p> | F0812 | <p>F 812</p> <p>Food Procurement</p> <p>CORRECTIVE ACTION</p> <p>The Dietician disposed of the expired orange juice on 3/23/26.</p> <p>IDENTIFICATION OF OTHERS</p> <p>The Dietician conducted an audit of all coolers and food storage areas on 3/27/26 and did not identify any other expired food.</p> <p>SYSTEMIC CHANGE</p> <p>Education was provided to the Dietary staff by the Dietician on 3/27/26 regarding disposing of any expired food items in the kitchens.</p> <p>The Dietary Manager/designee audits all food storage areas for expired food items daily and disposes of any items that are expired.</p> <p>MONITORING</p> <p>The Dietary Manager monitors for any items identified as past the expiration date daily 5 days per week. The results of this audit are reported to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.</p> | 05/08/2026 |

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| F0812 SS = D | Continued from page 14 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..." | F0812 | | 05/08/2026 |