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 08/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Rehabilitation and Wellness	**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 complaint survey was conducted by Healthcare Licensing and Surveys from 8/5/26 through 8/7/26 which was prompted by complaint intakes 2993051, 2975941, 3006270, 3008914, 3049529, 3049530, and 3134927. The following common abbreviations are used throughout this document: DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F0000		
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 interview, and performance improvement plan review, the facility failed to implement interventions and treatment to prevent the deterioration of wounds for 1 of 3 sample patients (#10) reviewed for skin conditions. The findings were: Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 6/22/26. 1. Review of the initial progress note by the nurse practitioner showed resident #10 was admitted to the facility on 4/9/26 for post-acute care following an	F0684	"Past Noncompliance - no plan of correction required"	

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0684 SS = D	Continued from page 1 inpatient hospitalization for RSV [respiratory syncytial virus]. The resident had a medical history which included dementia and chronic skin ulcers. The initial assessment showed the resident had a venous stasis ulcer to the outer right ankle. The following concerns were identified: a. Review of the progress note dated 4/10/26 showed the resident's "left extremity swollen and tight but intact, dry flaky skin washed off and moisture oint [ointment] applied. The right lower leg is very swollen with large ulcers that are open red moist to left inner ankle and right outer ankle, ulcer purple and red with moist center. Heel area is hard callous appearing very thick dried skin, as are large dry patches to lower extremity." The nurse practitioner examined the wounds and a culture was ordered. b. Review of the wound clinic examination on 5/28/26 showed the clinic performed an assessment and debridement of bilateral lower extremities. The wound clinic note showed that the "patient's primary care provider listed doxycycline as an allergy this week therefore...an antibiotic change...will be sent back to [facility name]." In addition, the wound care note showed that the resident was to return to the clinic in 1 week, and to "keep wraps to bilateral lower legs clean and dry until next clinic visit." An after-visit summary (AVS) and report of consultation were also included in the medical record dated 5/28/26. The AVS showed the resident was seen for a primary diagnosis of venous stasis ulcer of the right lower extremity and included upcoming appointment dates and times for podiatry and wound care. The follow up appointment for wound care was scheduled for 6/5/26 at 1 PM. The report of consultation showed "Pt [patient] may shower, please keep lower leg wraps covered, clean and dry until next visit. All wound care will be done in clinic." c. Review of a progress note for "Alert Charting: Skin Issue" on 6/9/26 showed "resident c/o [complaint of] legs hurting, increased edema at calf area. Wraps to BLE [bilateral lower extremities] from Wound clinic noted to have urine on them. Wraps removed wounds cleaned and foam protective dressings applied with alginate." d. Review of a 6/16/26 progress note for "Alert Charting: Medical Change of Condition" at 4:41 AM showed the "resident's BLE [bilateral lower extremity] wounds worsening. Goes back to wound clinic today 3:30 PM...C/o [complaint of] 8/10 pain. PRN [as needed] Tylenol 500mg not effective...legs	F0684		

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F0684 SS = D	Continued from page 2 hurting in bed BLE weeping, leaving puddle on floor and bedding. DON, after hours call NP [nurse practitioner] notified." e. Review of the progress note for "eINTERACT SBAR Summary for providers" on 6/16/26 at 5:20 PM showed that the "resident was admitted from [facility name] wound care clinic." f. Review of the medical record showed no evidence the patient went to the wound care clinic after the 5/28/26 visit until the visit on 6/16/26." 2. Interview with the DON on 8/7/26 at 2:06 PM revealed that the resident did not receive care at wound care clinic between 5/28/26 and 6/16/26 as the provider order for the 6/5/26 appointment was not obtained. The DON stated that the resident treatment with Lasix contributed to the weeping of the resident's wounds. The DON also stated that a PIP [Performance improvement plan] was conducted for wound care and for missed appointments for residents. 3. Review of the performance improvement plan for appointments, initiated on 6/16/26, showed corrective measures including audits of resident medical records for any missed or late appointments in the previous 30-day period, systemic change involved in-service education, reporting of missed appointments to the SSD (social services designee) or DON and initiated the SSD monitoring appointments daily and receiving follow-up documentation upon return of the resident to the facility to ensure orders are provided to nursing and additional appointments are made as necessary. In addition, the SSD was tasked with continued monitoring for late or missed appointments and reporting negative patterns or trends to the QAPI committee for review and resolution for a minimum of three months. 4. Review of the performance improvement plan for wound care, initiated 6/16/26, showed corrective action which included systemic change with in-service education provided to all licensed nurses related to wound evaluation and assessment and notification of actual and potential wound decline. The DON was tasked with reviewing any identified deterioration in wound status and reporting any negative patterns or trends to the QAPI committee for review and resolution for a minimum of three months.	F0684		