DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 49RX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: LTC0057

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 035131
2.STATE VENDOR OR MEDICAID NO.
(L2) 041070

3. NAME AND ADDRESS OF FACILITY
(L3) GRANITE CREEK HEALTH & REHABILITATION CENTER
(L4) 1045 SCOTT DRIVE
(L5) PRESCOTT, AZ (L6) 86301

4. TYPE OF ACTION: 2 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) 07/01/2015

6. DATE OF SURVEY 05/23/2019 (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12.Total Facility Beds 128 (L18)
13.Total Certified Beds 128 (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: A1* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	128			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
During an annual survey that was conducted on 05/23/2019 Granite Creek Health and Rehab was found to be out of both State and Federal compliance.

Based on an allegation of compliance and an acceptable plan of correction Granite Creek Health and Rehabilitation was placed back in to compliance on 07/03/2019.

17. SURVEYOR SIGNATURE — Date: 07/03/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date: 07/03/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/31/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
10301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

July 3, 2019

Important Notice - Please Read Carefully

Brian Lorenz
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Re: Provider Number 035131

Dear Mr. Lorenz:

Your facility has just undergone its Federal/State recertification survey, as required by the Federal Title XVIII (Medicare) program and Federal Title XIX (Medicaid/AHCCCS) program. As the result of this survey, the facility's Medicare Provider Agreement will be continuous, unless you are contacted by our Bureau or the Centers for Medicare/Medicaid Services to the contrary.

Please retain a copy of this notice with your signed provider agreement.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE/sg

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

July 3, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Brian Lorenz, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Lorenz:

On July 3, 2019, an offsite review was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations based on an allegation of compliance and acceptable plan of correction.

Enclosed is the **Federal Post-Certification Revisit Report**, please retain a copy for your files. If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Shoalynn Gilliland

Shoalynn Gilliland
Program Project Specialist II
Bureau of Long Term Care Licensing

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	R 07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
{F 000}	INITIAL COMMENTS The follow up Federal Recertification and complaint investigation survey was conducted 7/3/19, there were no deficiencies cited.	{F 000}		

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035131 Y1	A. Building B. Wing Y2	7/3/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 07/01/2019	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 07/01/2019	ID Prefix F0696 Reg. # 483.25(j) LSC	Correction Completed 07/01/2019
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) DA	DATE 7/3/19	SIGNATURE OF SURVEYOR Dale Colan	DATE 7/3/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/23/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

June 11, 2019

Receipt Of This Notice Is Presumed To Be -06/11/2019
Important Notice - Please Read Carefully

Brian Lorenz, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Lorenz:

On **May 23, 2019,** a Medicare recertification survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaints investigations may have also been conducted.

[] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (D).

[X] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (E).

[] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (F).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **June 21, 2019**. You must include all pages of the Statement of Deficiencies when submitting your PoC.
Failure to submit an acceptable PoC by **June 21, 2019** may result in the imposition of remedies. **Plans of correction sent by fax will not be accepted.**

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.

- The signature and date you approve the Plan of Correction on the first page.

- Please provide all in-service records to include:

    - What was taught
    - When it was taught
    - Sign-in sheets of those who attended
    - Any copies of monitoring aduits being done up to your Allegation of Compliance date

Allegation of Compliance

Your properly signed Plan of Correction constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means.

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of **July 8, 2019 .**

If, upon a subsequent revisit, your facility has not achieved substantial compliance, the Bureau of Long Term Care will recommend that remedies be imposed by the CMS Regional Office or the State Medicaid Agency and continue until substantial compliance is achieved.

Recommended Remedies

The remedies which will be recommended if substantial compliance is not achieved include the following:

Recommending to CMS Civil Money, effective May 23, 2019
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on May 23, 2019. If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. The CMS Regional Office must terminate your provider agreement if substantial compliance has not been reached by November 20, 2019.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the deficiencies may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Notice for Statutory Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory Denial of Payment for New Admissions effective August 22, 2019. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit.
This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid) The Medicare and Medicaid programs will make no payment for residents whose plans of care begin on or after the DPNA effective date.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the

finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent

you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, an explanation of why you are disputing those deficiencies along with supporting information that shows that the facility was in compliance at the time of the survey to Diane Eckles, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies.

An informal dispute resolution process will not delay the effective date of any enforcement action. **Please note: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**
Retain a copy of the PoC for your files. If the PoC is not received by this Office by **June 21, 2019,** licensure and/or recertification may be denied. **Plans of correction sent by fax will not be accepted.** If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles
Bureau Chief

DE:dc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 000	INITIAL COMMENTS The recertification survey was conducted on May 20, through May 23, 2019, in conjunction with the following Complaint investigations: AZ00153176 and AZ00156579. The following deficiencies were cited:	F 000	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did in fact exist; rather the facility is filing this document in order to comply with its obligations as provider participating in the Medicare/Medicaid program(s). The following Plan of Correction is intended to serve as a credible allegation of our intent to correct the practices identified as deficient and to implement the corrections as stated. DS (Initials)	
F 684 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 clinical record review, staff interviews and policy review, the facility failed to ensure that 1 of 21 sampled residents (#81) received treatments as ordered by the physician. Failure to implement physician orders could result in changes in conditions being missed and a lack of timely interventions being implemented. Findings include: Resident #81 was admitted on 12/28/18 and readmitted on 2/23/19, with diagnoses that included acute and chronic congestive heart failure, acute respiratory failure with hypoxia and pneumonia. The admission MDS (Minimum Data Set) assessment dated 1/4/19 included the resident	F 684	**F 684** **Corrective action for residents found to have been affected by this deficiency:** Resident #81 has been discharged. **Corrective action for residents that may be affected by the deficiency:** Residents with treatment orders and daily weight orders may be affected. Arizona Department of Heal Division of Public Health Licensing Services JUN 21 2019 RECEIVED JUN 24 2019 Reception Desk 150 N. 18th Ave #40(Phoenix, AZ 85007 By _____	

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

Administrator | 6/21/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 684	Continued From page 1 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact. A physician's order dated February 22, 2019 included to check oxygen saturation levels (O2 sats) and liter flow every shift; and to check O2 sats every shift on room air, when exerting himself. On February 24, 2019, a physician's order revealed for oxygen 1-4 liters per minute, per nasal cannula continuous and titrate to keep O2 sats greater than 90% every shift. Review of the February 2019 Medication Administration Record (MAR) revealed the above orders. However, there was no documentation that the O2 liter flow and O2 sats were checked on February 27 and 28, during the evening shift. According to the March 2019 MAR, there was no documentation that the O2 liter flow and O2 sats were checked on March 2. Regarding the physician orders for weights: A physician's order dated February 23, 2019 included for daily weights and to notify the physician of any weight change greater than 3 lbs in one day. Review of the March 2019 MAR revealed the resident weighed 174 pounds on March 4. Further review revealed that on March 5, the resident's weight was 180.4 pounds. A nursing progress note dated March 5, 2019 stated the resident was alert, oriented x 4 and	F 684	**Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were re-inserviced on following physician orders and documentation of implementation of physician orders. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Twice weekly audits of documentation of treatment and daily weight orders including notifications will be done. Corrective action will be implemented for any nurse not documenting the completion of physician treatment and weight notifications orders. Findings and analysis will be reported to the facility's QAA Committee monthly. Responsible: Director of Nursing Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 684	Continued From page 2 was anxious/agitated. The note stated the resident had an episode of anxiety today due to his breathing, feeling like he was not oxygenating well. Sats were checked and he was 90% on 2 liters of oxygen. A Small Volume Nebulizer (SVN) treatment was administered and he felt "a little better." This note did not address the resident's weight gain or that the physician was notified of the weight gain. Review of the clinical record revealed there was no documentation that the physician had been notified of the resident's weight gain at this time as ordered. An interview was conducted on May 22, 2019 at 12:09 p.m., with a Licensed Practical Nurse (LPN/staff #68). She stated the nurses work three shifts; days, evenings and night shift. She acknowledged there was missing documentation on the February and March MAR's for O2 monitoring. She also stated the resident's 6.4 lb weight gain on March 5 should have been immediately reported to the physician. She said her process would be to follow the physician's order. An interview was conducted on May 22, 2019 at 8:31 a.m., with the Director of Nursing (DON/staff #142). He stated his expectation is for the nurses to follow the physician's orders as they are written. The facility policy on Physician Orders dated August 2018 stated it is the policy of the facility to accurately implement orders...in accordance with the resident's plan of care.	F 684		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 686 SS=D	Continued From page 3 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and policy review, the facility failed to thoroughly assess a newly identified stage 2 pressure ulcer and notify the physician for treatment orders for one resident (#14). The deficient practice resulted in a delay in treatment, which could cause wound deterioration and complications. Findings include: Resident #14 was admitted to the facility on September 1, 2015, with diagnoses that included chronic kidney disease and cardiovascular disease. A quarterly Minimum Data Set (MDS) assessment dated December 4, 2018 revealed the resident scored an 8 on the brief interview for mental status, which indicated the resident had moderate cognitive impairment. The MDS included the resident was at high risk for pressure	F 686	**F 686** **Corrective action for residents found to have been affected by this deficiency:** Resident #14 has had a comprehensive wound assessment completed weekly by the facility's certified wound nurse, and by a contracted certified wound doctor. Treatments are being administered as ordered, and new pressure relieving interventions have been ordered and implemented. **Corrective action for residents that may be affected by the deficiency:** Any resident who may have a change of condition of skin integrity with wounds may be affected **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were re-inserviced that a change in skin integrity involving a wound requires notification of physician for treatment orders to avoid a delay in treatment. Licensed nurses were re-inserviced to notify the facility's wound nurse for a comprehensive assessment of the wound.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 686	Continued From page 4 ulcer development and did not have a current pressure ulcer. Per the MDS, the resident required extensive assistance with two staff for bed positioning. A care plan dated February 2019 documented a focus area of a potential for pressure ulcer development, due to immobility in bed and a history of pressure ulcer development. A goal was the resident would have no complications. Interventions included the following: -Notify the nurse immediately of any new areas of skin breakdown such as redness, blisters, bruises or discoloration. -Monitor/document/report to MD as necessary any changes in skin status such as appearance, color, wound healing, signs and symptoms of infection, wound size and stage. -Assess/record/monitor for wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician. -Follow facility policies and protocols for the prevention/treatment of skin breakdown. A weekly licensed nurse skin evaluation dated February 3, 2019 documented the identification of a wound on the right inner heel. The documentation included that treatment had been administered and documented on the Treatment Administration Record (TAR). However, there was no evidence of any measurements, a description of the wound, physician notification or the type of treatment that had been administered. Review of the clinical record including the physician orders, nursing progress notes, TARs	F 686	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Weekly audits of weekly skin assessments and progress notes will be completed on any resident with new wounds to determine if there is any delay in treatment. Findings and analysis will be reported to the facility's QAA Committee monthly. Responsible: Wound Nurse and Director of Nursing Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 686	Continued From page 5	F 686		

and care plans revealed no evidence of the right inner heel wound until February 7, 2019.

A weekly pressure ulcer form dated February 7, 2019 now revealed the resident had a fluid filled blister on the right medial heel, which was identified as a stage 2 pressure ulcer.

Further review of the clinical record revealed no evidence of physician notification or any treatment orders, and there was no documentation of any treatments that had been administered on the February 2019 TAR.

An interview was conducted with a Licensed Practical Nurse (staff #36) on May 22, 2019 at 12:47 p.m. Staff #36 stated she completed a clinical record review and a skin problem had been identified on February 3, 2019. Staff #36 stated there was no documentation of physician notification or wound descriptors. Staff #36 stated the usual protocol is for the nurse to notify the wound nurse and or the physician. Staff stated for resident #14, a skin problem had been identified however; no further action was taken until 4 days later on February 7, 2019.

An interview was conducted with the Director of Nursing (staff #142) on May 22, 2019 at 1:53 p.m. Staff #142 stated the facility protocol had not been put into place for this resident, because the physician had not been notified when a wound had been identified. Staff #142 stated the protocol was the same as outlined in the policy which includes that once a wound has been identified, assessed and documented, nursing shall administer treatment to the affected area as per the physician's orders. Staff #142 said that wound and skin treatments should be documented in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 686	Continued From page 6 clinical record at the time they are administered. According to a facility policy regarding wound management the following was included: A resident who enters the facility without pressure ulcers does not develop pressure ulcers...and a resident having pressure ulcers receives necessary treatment and services to promote healing. Once a wound has been identified, assessed, and documented nursing shall administer treatment to the affected area as per the physician's orders. All wound and skin treatments should be documented in the clinical record at the time they are administered.	F 686		
F 696 SS=E	Prostheses CFR(s): 483.25(j) §483.25(j) Prostheses The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and policy and procedures, the facility failed to ensure that care and assistance were provided to one resident (#30) with a prosthesis, which did not fit properly. The deficient practice could result in a decline in mobility and level of functioning, requiring more assistance and being more dependent. Findings include: Resident #30 was admitted on April 13, 2017,	F 696	**F 696** **Corrective action for residents found to have been affected by this deficiency:** Resident #30 has an appointment with a prosthetic company on June 21, 2019, for re-measurement and fitting of a new prosthesis. Facility was unable to obtain an earlier appointment, **Corrective action for residents that may be affected by the deficiency:** Residents with prosthesis may be affected, and **Measures that will be put into place to ensure that this deficiency does not recur:** Physical and occupational therapists were re-inserviced on follow-up for residents with ill-fitting prostheses. Licensed nurses and Unit Secretary were re-inserviced on follow-up appointments for residents with ill-fitting prosthetic devices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 696	Continued From page 7 with diagnoses that included ortho aftercare following surgical amputation of left leg below knee, chronic multifocal osteomyelitis and type 2 diabetes mellitus. Review of a physician's progress note dated 10/5/18 revealed the following: Evaluated and measured patient for new prosthesis. Current socket and foot no longer fit or function well. Will follow up for casting/scanning for new prosthesis. However, there was no clinical record documentation that the new prosthesis was obtained for the resident or the rational as to why this was not done from October 2018 through January 2019. A nursing progress note dated February 19, 2019 included a call was placed to the Nurse Practitioner (NP) to report a deep vein thrombosis was discovered via venous Doppler in the resident's right lower extremity (RLE). A quarterly MDS assessment March 23, 2019 revealed the resident scored 10 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The MDS also noted that the resident used a wheelchair. An Activities of Daily Living (ADL) care plan dated April 2, 2019, revealed the resident required assistance with ADL's related to decreased mobility, deconditioning and weakness. The goal was for the resident to gradually increase to an independent level in all ADL's including bed mobility, transfers, dressing, grooming, toilet use and personal hygiene through the next review. An intervention included for the Restorative Nurse Assistant (RNA) program: lower extremity	F 696	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Bi-monthly audits will be completed on residents with prosthetic devices for fit, and needed follow-up appointments. Findings and analysis will be reported to the QAA Committee monthly. Responsible: Director of Rehabilitation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 696	Continued From page 8	F 696		

strengthening exercises three times per week.

Review of a Physical Therapy (PT) Evaluation and Plan of Treatment dated May 1, 2019, revealed the following goals: the resident will safely perform bed mobility tasks with modified independence and functional transfers with stand by assistance. The approaches included for therapeutic exercises and activities, manual therapy and neuromuscular reeducation. The resident's goal was to get better at transfers and eventually walk again. Per the evaluation, the resident demonstrates good rehab potential as evidence by active participation in skilled treatment, able to make needs known and motivated to participate.

The PT evaluation also included the resident has had a significant decline over the past several months, due to a diagnosis of DVT to the right lower extremity and medical decline as well. He previously required 1 person assist with mobility and has had a prosthesis for his left lower extremity, but it does not fit properly. He has been non-ambulatory greater than 6 months and in bed the majority of time in the past few months. Resident is starting to feel better and is willing to participate with skilled PT. The evaluation did not include any plan to address the resident's prosthesis, which did not fit properly.

An interview was conducted on May 20, 2019 at 10:03 a.m., with resident #30. He stated the prosthesis for his left lower leg is too small for his stump. He stated that staff are aware and is doing nothing about it. He said he used to wear his prosthesis before he got a blood clot in his other leg, but since he got the blood clot he has been laying in bed, and it no longer fits. The resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 696	Continued From page 9 stated that with the prosthesis it made it easier to do the PT exercises and that he would like to get a new one that fits. An interview was conducted on May 22, 2019 at 8:16 a.m., with a Certified Nursing Assistant (CNA/staff #65). She stated the resident does have a prosthetic, but it doesn't fit him any more. She said she had not passed on the information that the prosthesis may be too small, because she doesn't always work the same hall and she hasn't remembered to tell anyone. An interview was conducted on May 22, 2019 at 8:25 a.m., with a Licensed Practical Nurse (LPN/staff #22). She stated the resident does have a prosthesis and that he was currently receiving restorative nursing to build up strength in the leg, which had the DVT. She said she knows of no other reason for him not to wear it. She said once he gets his strength back, he has no reason for not wearing it. She stated the prosthesis fit a few months back and was unaware of whether or not it fit now. An interview was conducted on May 22, 2019 at 8:31 a.m., with the Director of Nursing (DON/staff #142). He stated the resident receives PT and that they would have therapy evaluate him, get the NP and/or doctor involved and have someone in to re-measure the resident's stump. He stated they could certainly get him fitted and could get a referral ordered. On May 22, 2019 at 8:48 a.m., an interview was conducted with a Physical Therapist (staff #16). She said that PT picked him up to reassess for transfers and strengthening exercises (in May). She said the resident gained a lot of weight and	F 696		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
F 696	Continued From page 10 that his prosthetic leg didn't fit any more. She stated the resident comes to PT to do exercises and practices using the standing frame, and sometimes he tries to use the sliding board for transfers. She said that resident #30 seems to participate less in PT lately, and if he didn't participate they may have to drop him. She further stated that if the resident's prosthesis fit, it would definitely assist him in accomplishing his goals. Review of the facility policy on Prosthesis revised May 2007 revealed that assisting the resident to use all needed prostheses on a daily basis is part of standard care and shall be encouraged. Direct care staff, in recognition of functional ability and dignity issues, are responsible for seeing that all residents with artificial limbs are wearing these devices unless the resident refuses. Referrals to outside services or in-house therapy departments for repair, maintenance, or replacement are to be made through the nurse and/or Social Services Department and/or resident and/or a family member.	F 696		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

June 11, 2019

Receipt of This Notice is Presumed To Be 06/11/2019
Important Notice - Please Read

Brian Lorenz, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr. Lorenz:

On **May 24, 2019**, a recertification survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal/State participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed **Life Safety Code** deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. This form will become a part of your public file; **please sign and return the original** and retain a **copy** for your files.

If we may be of any further assistance please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\dc

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	**1045 SCOTT DRIVE** **PRESCOTT, AZ 86301**

(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
K 000	INITIAL COMMENTS 42 CFR 483.41(a) Nursing Home The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This is a Recertification survey for Medicare under LSC 2012, Chapter 19 Existing Nursing Home. The entire building was surveyed. The facility meets the standards, based upon compliance with all the provisions of the standards. No apparent deficiencies were found during the survey.	K 000	RECEIVED JUN 24 2019 By	

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

Administrator | 6/21/19

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.

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

June 11, 2019

Receipt of This Notice is Presumed To Be 06/11/2019
Important Notice - Please Read

Brian Lorenz, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr. Lorenz:

On **May 24, 2019**, a recertification survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal/State participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed **Emergency Preparedness** deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. This form will become a part of your public file; **please sign and return the original** and retain a **copy** for your files.

If we may be of any further assistance please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\dc

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

(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
E 000	Initial Comments 42 CFR 483.73 Long Term Care Facilities. The facility must meet all applicable Federal, State and local emergency preparedness requirements as outlined in the Medicare and Medicaid Programs: Emergency Preparedness Requirements of Medicare and Medicaid Participating Providers and Suppliers Final Rule (81 FR 63860) September 16, 2016. No apparent deficiences noted at the time of the survey.	E 000		

RECEIVED
JUN 24 2019
By

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

Administrator | 6/24/19

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.

DEPARTMENT OF HEALTH AND HUMAN SERV
CENTERS FOR MEDICARE & MEDICAID SERVIC

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey:

From: F1 *(mm/dd/yyyy)*: 5/20/19

To: F2 *(mm/dd/yyyy)*: 5/23/19

Extended Survey:

From: F3 *(mm/dd/yyyy)*:

To: F4 *(mm/dd/yyyy)*:

Name of Facility: Granite Creek Healthcare Rehabilitation

Provider Number: 035131

Fiscal Year Ending: F5 *(mm/dd/yyyy)*:

Street Address: 1045 Scott Drive

City: Prescott

County: Yavapai

State: AZ

Zip Code: 86301

Telephone Number: F6: 928-778-9603

State/County Code: F7:

State/Region Code: F8:

F9: 01

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

Is this facility hospital based? F10 ..... ○ Yes ○ No

If yes, indicate Hospital Provider Number: F11

Ownership: F12: 03

For-Profit	Non-Profit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal
13 Limited Liability Corporation			

Owned or leased by Multi-Facility Organization: F13 ..... ☒ Yes ○ No

Name of Multi-Facility Organization: F14: Ensign Services Group

Dedicated Special Care Units: *(show number of beds for all that apply)*

F15 AIDS	F16 Alzheimer's Disease	F17 Dialysis
F18 Disabled Children/Young Adults	F19 Head Trauma	F20 Hospice
F21 Huntington's Disease	F22 Ventilator/Respiratory Care	F23 Other Specialized Rehabilitation

Does the facility currently have an organized residents' group? F24 ..... ☒ Yes ○ No

Does the facility currently have an organized group of family members of residents? ..... ○ Yes ☒ No

Does the facility conduct experimental research? F26 ..... ○ Yes ☒ No

Is the facility part of a continuing care retirement community (CCRC)? F27 ..... ○ Yes ☒ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:

Date: F28 *(mm/dd/yyyy)*:

Hours waived per week: F29:

Waiver of 24 hr licensed nursing requirement:

Date: F30 *(mm/dd/yyyy)*:

Hours waived per week: F31:

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 ..... ○ Yes ☒ No

Name of Person Completing Form: Brigham Curran

Time: 08:00

Signature: Brigham Curran

Date: 5/21/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035131	10 F75	55 F76	24 F77	89 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 0	F80 47	F81 42
Dressing	F82 0	F83 62	F84 27
Transferring	F85 0	F86 68	F87 21
Toilet Use	F88 0	F89 63	F90 26
Eating	F91 0	F92 81	F93 8

A. Bowel/Bladder Status

F94 9 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 9 ?

F96 56 Occasionally or frequently incontinent of bladder

F97 42 Occasionally or frequently incontinent of bowel

F98 56 On urinary toileting program

F99 42 On bowel toileting program

B. Mobility

F100 2 Bedfast all or most of time

F101 72 In a chair all or most of time

F102 2 Independently ambulatory

F103 13 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0 ?

F106 8 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 8 ?

C. Mental Status

F108-114 – indicate the number of residents with:

F108 2 Intellectual and/or developmental disability

F109 14 Documented signs and symptoms of depression

F110 13 Documented psychiatric diagnosis (exclude dementias and depression)

F111 21 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112 0 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 0 ?

F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 – indicate the number of residents with:

F115 11 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 8 ?

F117 64 Receiving preventive skin care

F118 0 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 12 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 1 Dialysis

F123 4 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 22 Respiratory treatment

F125 0 Tracheostomy care

F126 4 Ostomy care

F127 0 Suctioning

F128 19 Injections (exclude vitamin B12 injections)

F129 1 Tube feedings

F130 23 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 30 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 0 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 51 Any psychoactive medication

F134 8 Antipsychotic medications

F135 20 Antianxiety medications

F136 44 Antidepressant medications

F137 3 Hypnotic medications

F138 16 Antibiotics

F139 74 On pain management program

G. Other

F140 0 With unplanned significant weight loss/gain

F141 2 Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 0 Who use non-oral communication devices

F143 89 With advance directives

F144 61 Received influenza immunization

F145 47 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
[signature]	DON	5/21/19

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? ✓ Yes ___ No

F147 Was ombudsman present during any portion of the survey? ✓ Yes ___ No

F148 Medication error rate 0 %

GRANITE CREEK HEALTH & REHABILITATION
1045 SCOTT DRIVE
PRESCOTT, AZ 86301
State's Region Code: AZ
Compliance Status: Provider meets requirements based on an acceptable plan of correction

CCN: 035131
Phone Number: (928)778-9603
Participation Date: 07/31/1986

Provider Beds
Total: 128
Certified: 128

Provider Category: SNF/NF (DUAL)
Type Action: RECERTIFICATION
Type Ownership: FOR PROFIT - CORPORATION

Program Requirements

Current Survey/Revisit Dates - None

ior 3 Survey 08/2014	S/S Code	Prior 2 Survey 11/2015	S/S Code	Prior 1 Survey 01/2017	S/S Code	Current Survey 03/15/2018	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	-	-	- -	-	-	REQ	F0157-NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
-	-	-	-	-	-	- -	-	-	REQ	F0160-CONVEYANCE OF PERSONAL FUNDS UPON DEATH
-	-	-	-	-	-	- -	-	-	REQ	F0204-PREPARATION FOR SAFE/ORDERLY
-	-	-	-	-	-	- -	-	-	REQ	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
-	-	-	-	-	-	- -	-	-	REQ	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
X	D	X	D	-	-	- -	-	-	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	-	-	-	-	- -	-	-	REQ	F0248-ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES
-	-	-	-	-	-	- -	-	-	REQ	F0272-COMPREHENSIVE ASSESSMENTS
-	-	-	-	-	-	- -	-	-	REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
-	-	-	-	-	-	- -	-	-	REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
-	-	-	-	-	-	- -	-	-	REQ	F0280-RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
-	-	-	-	-	-	- -	-	-	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
-	-	-	-	-	-	- -	-	-	REQ	F0282-SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
-	-	X	D	-	-	- -	-	-	REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
-	-	-	-	-	-	- -	-	-	REQ	F0312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
X	D	-	-	-	-	- -	-	-	REQ	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
-	-	-	-	-	-	- -	-	-	REQ	F0325-MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE
-	-	-	-	-	-	- -	-	-	REQ	F0327-SUFFICIENT FLUID TO MAINTAIN HYDRATION
-	-	-	-	-	-	- -	-	-	REQ	F0328-TREATMENT/CARE FOR SPECIAL NEEDS
X	D	-	-	-	-	- -	-	-	REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
-	-	-	-	-	-	- -	-	-	REQ	F0333-RESIDENTS FREE OF SIGNIFICANT MED ERRORS
-	-	-	-	-	-	- -	-	-	REQ	F0334-INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS
X	F	X	D	X	E	- -	-	-	REQ	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
-	-	-	-	-	-	- -	-	-	REQ	F0411-ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
-	-	-	-	-	-	- -	-	-	REQ	F0428-DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON
-	-	-	-	-	-	- -	-	-	REQ	F0431-DRUG RECORDS, LABEL/STORE DRUGS &

GRANITE CREEK HEALTH & REHABILITATION **CCN:** 035131

Prior 3 Survey 08/2014	S/S Code	Prior 2 Survey 11/2015	S/S Code	Prior 1 Survey 01/2017	S/S Code	Current Survey 03/15/2018	S/S Code	Plan/Date of Correction		Requirement
-	-	X	D	X	D	- -	-	-	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
-	-	-	-	-	-	- -	-	-	REQ	F0500-OUTSIDE PROFESSIONAL RESOURCES-
-	-	-	-	-	-	- -	-	-	REQ	F0502-ADMINISTRATION
X	B	-	-	-	-	- -	-	-	REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 08/2014	S/S Code	2012 HC Prior 2 Survey 11/2015	S/S Code	2012 HC Prior 1 Survey 01/2017	S/S Code	2012 HC Current Survey 03/15/2018	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	-	-	-	-	- -	-	-	STD	K0232-Aisle, Corridor, or Ramp Width
-	-	-	-	-	-	- -	-	-	STD	K0281-Illumination of Means of Egress
-	-	-	-	-	-	- -	-	-	STD	K0321-Hazardous Areas - Enclosure
-	-	-	-	-	-	- -	-	-	STD	K0353-Sprinkler System - Maintenance and Testing
-	-	-	-	-	-	- -	-	-	STD	K0363-Corridor - Doors
-	-	-	-	-	-	- -	-	-	STD	K0511-Utilities - Gas and Electric
-	-	-	-	-	-	- -	-	-	STD	K0923-Gas Equipment - Cylinder and Container Storag

GRANITE CREEK HEALTH & REHABILITATION CCN: 035131

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	0	2	4	5
Health Total	0	2	4	5
' ife Safety Code	0	0	0	0
.e Safety Code + Health	0	2	4	5

Complaint Survey Information

Survey Date	Status
03/15/2018	Unsubstantiated
01/26/2017	Unsubstantiated
11/05/2015	Substantiated
08/28/2014	Unsubstantiated

GRANITE CREEK HEALTH & REHABILITATION CCN: 035131

LTC Resident Census

Resident Census on 03/15/2018
Total: 84
Medicare: 15
Medicaid: 48
Other: 21

Total Certified Beds: 128

SNF	SNF/NF	NF	ICF/IID
0	128	0	0

Supplemental POC Documents

In-service Attendance Record

Course Title: Daily Weights Documentation / Physicians Notification Wound care a Physicians Notification

Date: 6/12/19 From: _____ To: _____ Length: _____

Subject: _____

Presented by: _____ DON
Signature and Title

Program: Orientation ≤ In-Service © Certification ≤

In-service: Attach Lesson Plan with behavioral objectives, core curriculum, method(s) of teaching, method of evaluation

Print Name	Title	Shift	Signature
Daniel M. Jimenez	CNA	DAY	Daniel M. Jimenez
Maria Aragon	CNA	Day/Eve	Maria Aragon
Effie	CNA	Eve	Effie
Carine Smith	CNA	Eve	Carine Smith
Jackie Morrison	CNA	Day CNA	Jackie Morrison
Nancy Vandervort	CNA	6-2	N. Vandervort
Nicole Jenkins	CNA	2-10pm	Nicole Jenkins
Troylyn Taylor	LPN	6-2	Taylor
Denise Guajardo	CNA	6-2	
Mary Brooks	CNA	2-10	Mary Brooks
Margaret Doty	CNA	2-10	
	RN		
mdumlao	RN	2-10	mdumlao
Jesse Spain		2-10	
Dawn Hann	LPN	6-6	

In-service Attendance Record

Course Title: State Survey Results, Follow Physicians Orders, Prosthetics F/U, Daily weight Documentation & Phys reporting, wound care

Date: 5/30/19 From: ______ To: ______ Length: ______

Subject: Overview of May 9, 2019 Fullscale exercise

Presented by: Mike Rassmusun / [signature]
Signature and Title

Program: Orientation ☐ In-Service ☐ Certification ☐

In-service: Attach Lesson Plan with behavioral objectives, core curriculum, method(s) of teaching, method of evaluation

Effie Barker CNA Evening [signature]

Print Name	Title	Shift	Signature
Jackie Morrison	CNA	DAY	Jackie Morrison
Larissa Odis	DOR	Day	[signature]
[illegible]	DON		[signature]
Jennifer Berger	RN	NOC	[signature]
Lidia Kraut	Hkp/laun	Day	[signature]
Rosemary Martin	CNA	Day	Rosemary Martin
Jesie Greenley	RN	D	[signature]
Julie Juberg	CNA	Day	J. Juberg
Douglas Johnson	RN	Noc	[signature]
Cindy Hicks	Dietary		Cindy Hicks
Beth Dorr	PT	Day	[signature]
Crystal Heller	CNA	DAY	Crystal Heller
Maria Jimenez	HSKP	DAY	[signature]
Maria Garcia	Laundry	PM	[signature]
Jesse [illegible]	[illegible]	Eve	[signature]
Tonya Doty	Staff/unit	Day	Tonya Doty
John Godwin	MDS	Days	[signature]
Dawn Hann	LPN	Days	[signature]
Ana Lecanus	LPN	Day	[signature]
Jackey Korte	Recep	Day	Jackey Korte
Sandy Price	[illegible]	Day	Sandy Price
Janet Ba[illegible]	HIT		[signature]
Marie T. Rakers	OTR	Day	Marie T. Rakers
George Mendez	Dir of Marketing		George Mendez
Leny Vermillion	D.A	PM	Elenita Vermillion
Marylou Doty	CNA	NOC	[signature]

Deann Bristol CNA DAY DBristol

Pamela Tryon ACT [signature]

Michelle Johnson RN DAY M. Johnson RN

9/2007

Patrice Meckling [signature]

Brianne Ray [illegible]

Maria Aragon CNA Day/Eve Maria Aragon

Charlotte McKinson CNA EVE Charlotte [signature]

Leslie Stuller HR/payroll [signature]

In-service Attendance Record

Course Title: Prosthetic Management

Date: 6/20/19 From: 12pm To: 12:40pm Length: 40 min

Subject: prosthetic fitting & management

Presented by: [signature] OT DOR
Signature and Title

Program: Orientation ≤ (In-Service ©) Certification ≤

In-service: Attach Lesson Plan with behavioral objectives, core curriculum, method(s) of teaching, method of evaluation

Print Name	Title	Shift	Signature
Beth Dorr	PT		BD
Carol Pettus	COTA		Carol Pettus OT
Tara Kent	PTA		
Anita Holguin	COTA		Anita Holguin
Maria Thelma Rakun	OTR/L		Maria T Rakun, OTR/L
Constanza Beebe	SLP		Constanza Beebe SLP.

In-service Attendance Record

Course Title: Survey Results - Dr. Orders; Daily Wts; Flu appt.

Date: 6/17/19 From: 2p To: 2:15p Length: 15min.

Subject: Flu apt.'s in PCC, Dr. Orders, Flu, Daily wts

Presented by: _____
Signature and Title

Program: Orientation ≤ In-Service © Certification ≤

In-service: Attach Lesson Plan with behavioral objectives, core curriculum, method(s) of teaching, method of evaluation

Print Name	Title	Shift	Signature
Holly Blassingame	RN	6A-6P	Holly Blassingame RN
Ana Vecano	LPN	6A-6P	
Jesse Sen	En	2-10	
Rose Green	RN	D	
T Taylor LPN	LPN	6-2	Trayla Taylor
	LPN	Day/Eve	
Dawn Hanna	RN	8-6	

In-service Attendance Record

Course Title: Survey Results - Dr. Orders; Daily Wts; Flu appt.

Date: 6/17/19 From: 2p To: 2:15p Length: 15min.

Subject: Flu apt.'s in PCC, Dr. Orders Flu, Daily wts.

Presented by: _____
Signature and Title

Program: Orientation ≤ In-Service © Certification ≤

In-service: Attach Lesson Plan with behavioral objectives, core curriculum, method(s) of teaching, method of evaluation

Print Name	Title	Shift	Signature
Holly Blassingame	RN	6A-6P	Holly Blassingame RN
Ana Alcaraz	LPN	6A-6P	
Jesse Sen	En	2-10	
Josie Green	RA	D	
T Taylor LPN	LPN	6-2	Traylyn Taylor
	LPN	Day/Eve	
Dawn Hanna	CNA	8-6	

Facility Name: Granite Creek **Date of Survey:** 5/2019

#	Role	Name	Hire Date	TB Status Current or PTSW (✓)	License Current/ Active (✓)	Finger-prints (✓)	CPR Current or N/A (✓)	First Aid Current or N/A (✓)	Orientation or Inservice (✓)	Job Description (signed) (✓)
	RN	Josefina Greenley	7/1/2015	✓	✓	✓	✓		✓	✓
	RN	Suzie Lake	3/23/2018	✓	✓	✓	✓		✓	✓
	LPN	John Goodwin	8/7/2015	✓		✓	✓		✓	✓
	LPN	Iris Baker	3/25/2019	✓	✓	✓	✓		✓	✓
	CNA	DeAnn Bristol	10/12/2016	✓	✓	✓	✓		✓	✓
	CNA	Maria Aragon Lopez	1/22/2019	✓	✓	✓	✓	✓	✓	✓
Complete Personnel Record review for all roles listed above and select **AT LEAST** eight (8) other roles from below for review, as applicable for the facility										
	PT/~~PTA~~	Kathryn Cartwright	1/22/2019	✓	✓	✓	✓		✓	✓
	OT/~~COTA~~	Amanda Branski	4/30/2018	✓	✓	✓	✓		✓	✓
	ST	Ann Carlson-Willette	5/20/2016	✓	✓	✓	✓		✓	✓
	Hskg	Elena Jimenez	7/1/2015	✓	-	-	-		✓	✓
	ACT	Leslie Cate	4/24/2019	✓	-	✓	-		✓	✓
	DA	Dawn Price	9/18/2016	✓	✓	-	✓		✓	✓
	SS	Heather Bowman	2/11/2019	✓	-	✓	-		✓	✓
	Maint	Shawn Halgeson	7/18/2016	✓	-	-	-		✓	✓
	RT		/ /							
	Vol		/ /							
	Std.		/ /							
			/ /							

RN = Registered; LPN = Licensed Practical Nurse; CNA = Certified Nursing Assistant; Pt = Physical Therapist; PTA = Physical Therapy Assistant; OT = Occupational Therapist; COTA = Certified Occupational Therapy Assistant; ST = Speech Therapist; Hskg = Housekeeping; ACT = Activities; DA = Dietary Aid; SS = Social Service; Maint = Maintenance; RT = Respiratory Therapist; Vol = Volunteer; Std = Student

PTS – Prior to starting work; Include dates in sections that are NOT Compliant, otherwise use check mark (✓)

Personnel Record Review Completed by: Name: [signature] **Surveyor #:** 21946 **Date:** 5/21/19

In-service Attendance Record

Course Title: Daily Weight Documentation / Physician Notification
Wound care & physician notification

Date: 6/12/19 From: ________ To: ________ Length: ________

Subject: ________________________________

Presented by: [signature] DON
Signature and Title

Program: Orientation ≤ In-Service © Certification ≤

In-service: Attach Lesson Plan with behavioral objectives, core curriculum, method(s) of teaching, method of evaluation

Print Name	Title	Shift	Signature
Daniel M. Jimenez	CNA	Day	[signature]
Maria Aragon	CNA	Day/Eve	[signature]
Effie	CNA	Eve	[signature]
[illegible]	CNA	Eve	[signature]
Jackie Morrison	CNA	Day CNA	Jackie Morrison
Nancy Vandervort	CNA	6-2	[signature]
Nicole Jenkins	CNA	2-10pm	[signature]
Troylyn Taylor	LPN	6-2	[signature]
Denise Guajardo	CNA	6-2	[signature]
Mary Brooks	CNA	2-10	[signature]
[illegible]	CNA	2-10	[signature]
[illegible]	RN		[signature]
Mdumlao	RN	2-10	Mdumlao
Jesse [illegible]	LN	2-10	
[illegible]	LPN	8-6	[signature]

In-service Attendance Record

Course Title: State Survey Results, Follow Physicians orders, Prosthetics F/U, Daily weight Documentation & Phys reporting wound care

Date: 5/30/19 From: ______ To: ______ Length: ______

Subject: Overview of May 9, 2019 Fullscale exercise

Presented by: Mike Rassmusun /
Signature and Title

Program: Orientation ☐ In-Service ☐ Certification ☐

In-service: Attach Lesson Plan with behavioral objectives, core curriculum, method(s) of teaching, method of evaluation

Print Name	Title	Shift	Signature
Effie Barker	CNA	Evening	[signature]
Jackie Morrison	CNA	DAY	Jackie Morrison
Larissa Oddy	DOR	Day	[signature]
[illegible]	DON		[signature]
Jennifer Beiley	RN	NOC	[signature]
Lidia Kraut	Hkp/Laun	Day	[signature]
Rosemary Martin	CNA	Day	Rosemary Martin
Josie Greenlay	RN	D	[signature]
Julie Juberg	CNA	Day	J. Juberg
Douglas Johnson	RN	Noc	[signature]
Cindy Hicks	Dietary		[signature]
Beth Dorr	PT	Day	[signature]
Crystal Heller	CNA	DAY	Crystal Heller
Maria Jimenez	HSKP	DAY	[signature]
Maria Garcia	Laundry	PM	[signature]
Jesse Sm	[illegible]	Eve	[signature]
Tonya Doty	Staff/unit	Day	Tonya Doty
John Goodwin	MDS	Days	[signature]
Dawn Harris	LPN	Days	[signature]
Ana Ukanis	LPN	Day	[signature]
Jackey Korte	Recep	Day	Jackey Korte
Sandy Price	ABOM	Day	Sandy Price
Janet Ba	HII		[signature]
Maria T. Rakun	OTR	Day	Maria Rakun
Georgi Mendy	Dir of Marketing		Georgi Mendy
Lenny Vermilla	D-A	PM	Elenita Vermilla
Marylou Doty	CNA	NOC	[signature]
Deann Bristol	CNA	DAY	D Bristol
Pamela Tryon	ACT		[signature]
Michelle Johnson	RN	DAY	M. Johnson RN
Patrice Mecklin			[signature]
Brianne Ray	[illegible]		
Maria Alvarado	CNA	Day/Eve	Maria Alvarado

Charlotte McKimson CNA EVE [signature]

HR/payroll Leslie Stuller [signature]

9/2007

In-service Attendance Record

Course Title: Prosthetic Management

Date: 6/20/19 From: 12pm To: 12:40pm Length: 40 min

Subject: prosthetic fitting & management

Presented by: [signature] OT DOR
Signature and Title

Program: Orientation ≤ (In-Service ©) Certification ≤

In-service: Attach Lesson Plan with behavioral objectives, core curriculum, method(s) of teaching, method of evaluation

Print Name	Title	Shift	Signature
Beth Dorr	PT		BD
Carol Pettus	COTA		Carol Pettus OT
Tara Kent	PTA		
Anita Holguin (Anit- Holguin)	COTA		Anita Holguin
Maria Thelma Rakun	OTR/L		Maria T Rakun OTR/L
Constanza Beeke	SLP		Constanza Beeke SLP.