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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7V18

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 **03/15/2018** (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
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 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):
A recertification survey was conducted on March 15, 2018 and no deficiencies were found.

17. SURVEYOR SIGNATURE
DE
for Matthew Connolly
Date: 03/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
VDE
Sandy Farmer
Date: 03/27/2018 (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

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

March 27, 2018

Brigham Curran
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Re: Provider Number 035131

Dear Mr. Curran:

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/sf

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 _____	03/15/2018

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 March 12 through 15, 2018, in conjunction with the investigation of Complaint #'s AZ00147042, AZ00145518, AZ00146324 and AZ00144324. No deficiencies were cited.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Cuma — TITLE: Executive Director — (X6) DATE: 3/28/18

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

Receipt of Notice Presumed 03/20/2018 via email

March 20, 2018

Brigham Curran, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr Curran:

On **March 15, 2018**, an annual 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. During this survey, complaint investigations may have also been conducted.

The enclosed Federal 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\sf

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 _____	**03/13/2018**

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. Comment only: The facility has scheduled per a memorandum from Intelligrated to conduct an Annual service on the fire shutter door in the main kitchen on March 20, 2018.	K 000		

RECEIVED
MAR 30 2018
By

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

Executive Director 3/28/18

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 _____	03/13/2018

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 deficiences noted at the time of the survey.	E 000		

RECEIVED
MAR 30 2018
By

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Cuma
TITLE: Executive Director
(X6) DATE: 3/28/18

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

Receipt of Notice Presumed 03/20/2018 via email

March 20, 2018

Brigham Curran, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr Curran:

On **March 15, 2018**, an annual 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. During this survey, complaint investigations may have also been conducted.

The enclosed Life Safety Code/EP 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\sf

Attachments

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

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 03 12 18 (MM DD YY) To: F2 03 15 18 (MM DD YY)

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F4 ☐☐ ☐☐ ☐☐ (MM DD YY)

Name of Facility	Provider Number	Fiscal Year Ending: F5 (MM DD YY)
Granite Creek Health & Rehabilitation Center	03-5131	☐☐ ☐☐ ☐☐

Street Address	City	County	State	Zip Code
1045 Scott Drive	Prescott	Yavapai	AZ	86301

Telephone Number: F6	State/County Code: F7	State/Region Code: F8
928-778-9603	120	AZ

A. F9 01

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

B. Is this facility hospital based? F10 Yes ☐ No ☑

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 03

For Profit	NonProfit	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

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?	F25	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 YY) Hours waived per week: F29 NA
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31 NA

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☑

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33				0	0	6	9	8	0	0	0	6	4	0	0	0	0	0
Physician Services	F34	Y	N	N															
Medical Director	F35				0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Other Physician	F36				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physician Extender	F37	Y	N	N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nursing Services	F38	Y	N	N															
RN Director of Nurses	F39				0	0	0	8	0	0	0	0	0	0	0	0	0	0	0
Nurses with Admin. Duties	F40				0	0	2	9	3	0	0	0	0	0	0	0	0	0	0
Registered Nurses	F41				0	0	4	3	2	0	0	0	0	0	0	0	0	0	0
Licensed Practical/ Licensed Vocational Nurses	F42				0	0	8	4	3	0	0	1	0	6	0	0	0	6	3
Certified Nurse Aides	F43				0	2	5	8	2	0	0	1	7	4	0	0	0	0	0
Nurse Aides in Training	F44				0	0	0	7	7	0	0	0	0	0	0	0	0	0	0
Medication Aides/Technicians	F45				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacists	F46	Y	N	N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Dietary Services	F47	Y	N	N															
Dietitian	F48				0	0	0	0	0	0	0	0	0	0	0	0	0	2	4
Food Service Workers	F49				0	0	3	8	5	0	0	1	9	8	0	0	0	0	0
Therapeutic Services	F50																		
Occupational Therapists	F51	Y	N	N	0	0	1	5	8	0	0	0	0	8	0	0	0	0	0
Occupational Therapy Assistants	F52				0	0	1	3	3	0	0	0	0	0	0	0	0	0	0
Occupational Therapy Aides	F53				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical Therapists	F54	Y	N	N	0	0	0	7	9	0	0	0	0	0	0	0	0	0	0
Physical Therapists Assistants	F55				0	0	1	3	6	0	0	0	0	0	0	0	0	0	0
Physical Therapy Aides	F56				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Speech/Language Pathologist	F57	Y	N	N	0	0	0	5	1	0	0	0	0	0	0	0	0	0	0
Therapeutic Recreation Specialist	F58	N	N	N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Qualified Activities Professional	F59	Y	N	N	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0
Other Activities Staff	F60	Y	N	N	0	0	0	4	7	0	0	0	5	6	0	0	0	0	0
Qualified Social Workers	F61	Y	N	N	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0
Other Social Services	F62	Y	N	N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dentists	F63	Y	N	N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Podiatrists	F64	Y	N	Y	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health Services	F65	Y	N	Y	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vocational Services	F66	N	N	N															
Clinical Laboratory Services	F67	Y	N	Y															
Diagnostic X-ray Services	F68	Y	N	Y															
Administration & Storage of Blood	F69	N	N	N															
Housekeeping Services	F70	Y	N	N	0	0	4	8	8	0	0	0	7	9	0	0	0	0	0
Other	F71				0	0	1	7	4	0	0	0	0	0	0	0	0	0	0

Name of Person Completing Form	Brigham Curran	Time	08:00
Signature	Brigham Curran	Date	3/13/18

Form CMS-671 (12/02)

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	15 F75	48 F76	21 F77	84 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 0	F80 41	F81 43
Dressing	F82 0	F83 70	F84 14
Transferring	F85 0	F86 70	F87 14
Toilet Use	F88 0	F89 61	F90 23
Eating	F91 11	F92 66	F93 7

A. Bowel/Bladder Status

F94 4 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 4 ?

F96 50 Occasionally or frequently incontinent of bladder

F97 39 Occasionally or frequently incontinent of bowel

F98 50 On urinary toileting program

F99 39 On bowel toileting program

B. Mobility

F100 0 Bedfast all or most of time

F101 61 In a chair all or most of time

F102 0 Independently ambulatory

F103 23 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 0 Intellectual and/or developmental disability

F109 26 Documented signs and symptoms of depression

F110 16 Documented psychiatric diagnosis (exclude dementias and depression)

F111 24 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 9 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 5 ?

F117 66 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 14 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 0 Dialysis

F123 5 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 14 Respiratory treatment

F125 0 Tracheostomy care

F126 2 Ostomy care

F127 0 Suctioning

F128 17 Injections (exclude vitamin B12 injections)

F129 1 Tube feedings

F130 18 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 23 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 4 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 32 Any psychoactive medication

F134 6 Antipsychotic medications

F135 27 Antianxiety medications

F136 26 Antidepressant medications

F137 4 Hypnotic medications

F138 14 Antibiotics

F139 54 On pain management program

G. Other

F140 4 With unplanned significant weight loss/gain

F141 0 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 84 With advance directives

F144 51 Received influenza immunization

F145 45 Received pneumococcal vaccine

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

Signature of Person Completing the Form	Title	Date
Nan Cooley	DON	3/12/2018

TO BE COMPLETED BY SURVEY TEAM

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

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

F148 Medication error rate 0 %

ADHS
LICENSING

Notice of Inspection Rights

Facility/Agency Name: Granite Creek Health & Rehabilitation Center

Address: 1045 Scott Drive		City: Prescott	Zip: 86301
Facility I.D.#: LTC0057	License #: NCI-2728	Medicare #: 035131	Date of Inspection: March 12, 2018

Survey Event ID: 7V1811

Inspector/Team Coordinator: Matt Connolly

Accompanied By: Chris Benson, Jeanne Castro, Michael Marek, Guadalupe Perez, and Sage Milton

BUREAU OF LONG TERM CARE LICENSING

This inspection is conducted under the authority of:

1. Arizona Revised Statutes (A.R.S.) Title 36, Chapters 1 and 4, and Arizona Administrative Code (A.A.C.), Title 9, Chapter 10. Some of the activities during the inspection may include, but are not limited to, a facility premise inspection, review and/or copying of records, including personnel records, interviews with residents/patients/clients, family and staff, and review of services offered.
2. The purpose of this inspection is to:
   - ☒ Determine compliance with health care institution requirements pursuant to the above A.R.S. and A.A.C.
   - ☒ Conduct a complaint investigation.
3. No fees are charged for this inspection.
4. An authorized representative of this facility may accompany the inspector(s) during the inspection conducted on these premises, except during any confidential interview.
5. You have the right to receive copies of any original documents taken by the inspector(s) during the inspection in those cases where the agency has authority to take original documents.
6. You and your staff have the opportunity to provide any information that would clarify an issue. Additionally, interviews with staff, family or residents/patients/clients may be conducted privately. Each person interviewed will be informed that statements made by the person may be included in the inspection report and each person whose conversations are tape or video recorded will be informed that the conversation is being tape or video recorded.
7. Upon completion of the inspection the inspector(s) will conduct an exit interview and informally disclose their findings. A Statement of Deficiencies (SOD) formally notifying you of the findings will be provided within 30 working days. You will be afforded an opportunity to submit a Plan of Correction (POC) unless the Department is considering enforcement against the license.
8. You have an opportunity to dispute any findings of non-compliance through an Informal Dispute Resolution (IDR). Details of the IDR process will be provided when the SOD is mailed to you.
9. If you have questions regarding this inspection, you may contact: Diane Eckles, Bureau Chief, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2675, FAX: (602) 324-0993, E-Mail: Diane.Eckles@azdhs.gov. If you have an issue that you cannot resolve with the Bureau or the Division, you may contact the Office of Ombudsman-Citizens' Aide, 3737 N. 7th St., Suite 209, Phoenix, AZ 85014 (602) 277-7292.
10. Your administrative hearing rights are found at A.R.S. § 41-1092 et seq., and rights relating to appeal of a final agency decision can be found in A.R.S. §12-901 et seq.

Upon entry to the premises for this inspection, the inspector(s) presented photo identification indicating that they are Arizona Department of Health Services (ADHS) employees and reviewed with me the above Notice of Inspection Rights. I have read the disclosures and am notified of my inspection and due process rights as listed. I understand that while I have the right to decline to sign this form, the ADHS representative(s) may proceed with the inspection.

[signature] 3/12/18

Administrator/Director/Agency Representative Signature Date:

☐ Administrator/Director/Agency Representative refused to sign this form.
☐ Administrator/Director/Agency Representative or authorized on-site representative is not present.

[signature] 3/12/18

Inspector/Team Coordinator Signature: Date:

☒ Copy left with Administrator/Director/Agency Representative

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CASPER Report 0003D
Provider History Profile
Report Selection Criteria

Run Date: 03/09/2018
Job # 67012230
Last Update: 03/08/2018

Criteria selected for this report:

Geographical Breakdown: State
State(s): AZ
Provider Categories: 02-Skilled Nursing Facility/Nursing Facility (Dually Certified);03-Skilled Nursing Facility/Nursing Facility (Distinct Part);04-Skilled Nursing Facility;10-Nursing Facility;11-Intermediate Care Facility/Individuals with Intellectual Disabilities
Provider Lookup?: Y
Survey from: 03/09/2014
Survey thru: 03/09/2018
Provider Status: Active
Survey Selection: Current Survey
Print Survey Team Information?: N
Print Surveyor ID #'s?: N
CCNs: 035131
Sorted by: CCN

GRANITE CREEK HEALTH & REHABILITATION
1045 SCOTT DRIVE
PRESCOTT, AZ 86301
State's Region Code: AZ

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

Compliance Status: Provider meets requirements based on an acceptable plan of correction

Program Requirements

Current Survey/Revisit Dates - 03/06/2017

Prior 3 Survey 05/2013	S/S Code	Prior 2 Survey 08/2014	S/S Code	Prior 1 Survey 11/2015	S/S Code	Current Survey 01/26/2017	S/S Code	Plan/Date of Correction		Requirement
X	D	-	-	-	-	- -	-	-	REQ	F0157-NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
X	B	-	-	-	-	- -	-	-	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	X	D	- -	-	-	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	-	-	-	-	- -	-	-	REQ	F0248-ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES
-	-	-	-	-	-	- -	-	-	REQ	F0272-COMPREHENSIVE ASSESSMENTS
X	D	-	-	-	-	- -	-	-	REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
X	D	-	-	-	-	- -	-	-	REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
X	E	-	-	-	-	- -	-	-	REQ	F0280-RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
-	-	-	-	-	-	- -	-	-	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
X	D	-	-	-	-	- -	-	-	REQ	F0282-SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
X	D	-	-	X	D	- -	-	-	REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
X	D	-	-	-	-	- -	-	-	REQ	F0312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
X	E	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	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	D	X	F	X	D	X C	E	03/05/2017	REQ	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
-	-	-	-	-	-	- -	-	-	REQ	F0411-ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
X	D	-	-	-	-	- -	-	-	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 05/2013	S/S Code	Prior 2 Survey 08/2014	S/S Code	Prior 1 Survey 11/2015	S/S Code	Current Survey 01/26/2017	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	X	D	X C	D	03/05/2017	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 05/2013	S/S Code	2012 HC Prior 2 Survey 08/2014	S/S Code	2012 HC Prior 1 Survey 11/2015	S/S Code	2012 HC Current Survey 01/26/2017	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
X	D	-	-	-	-	- -	-	-	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	2	4	5	13
Health Total	2	4	5	13
Life Safety Code	0	0	0	1
Life Safety Code + Health	2	4	5	14

Complaint Survey Information

Survey Date	Status
01/26/2017	Unsubstantiated
11/05/2015	Substantiated
08/28/2014	Unsubstantiated
05/23/2013	Substantiated

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

LTC Resident Census

Resident Census on 01/26/2017
Total: 84
Medicare: 11
Medicaid: 56
Other: 17

Total Certified Beds: 128

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

! = Past Non-compliance C = Date of Correction N = No Date Given P = Plan of Correction R = Refused to Correct W = Waived F = FSES X = Deficient
* = Regional Office Flag (Includes COPs) ELE = Element STD = Standard COP = Condition REQ = Requirement - = No Data Entered

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

March 20, 2018

Brigham Curran, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Re: Complaint Intake #AZ00144324
Investigation # 7V1811

Dear Mr. Curran:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

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

Sincerely,

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

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