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

MEDICA MEDICAID CERTIFICATION AND TRANSM AL

ID: 9VH212

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: **9** (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)

6. DATE OF SURVEY (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 (L18)

13.Total Certified Beds (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
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Granite Creek Health and Rehab Center was found to be out of compliance with federal regulations based on an abbreviatedl survey conducted on 7/2/2020. Granite Creek Health and Rehab Center is back in compliance with federal regulations based on an allegation of compliance and acceptable plan of correction with evidence of compliance. An onsite revisit survey completed on 9/16/2020 was deficiency free.

17. SURVEYOR SIGNATURE DE
for Johnna High, Surveyor JJ
Date: 09/17/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL DE
Sandy Turner
Date: 09/17/2020 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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 (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.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

September 17, 2020

Receipt Of This Notice Is Presumed To Be 09/17/2020
Important Notice - Please Read Carefully

Sean Hill, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Hill:

On September 16, 2020, an onsite revisit 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 requirements at the time of the focused infection control survey #9VH212.

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.

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,

Sandy Farmer

Sandy Farmer
LTC Customer Service Representative IV

\sf

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-C 09/16/2020

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 An onsite follow up visit to the complaint Survey (9VH11) was conducted September 15 through 16, 2020. No deficiencies were 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.

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 _____	C 07/02/2020

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

ARIZONA DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
LICENSING
AUG 20 2020

(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 investigation of Complaint #AZ00165552 was conducted from June 30, 2020 through July 2, 2020. The following deficiency was cited:	F 000	LONG TERM CARE 150 N. 18TH AVE # 440 PHOENIX, AZ 85007 *This plan of correction is the facility's credible allegation of compliance.*	
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880	*This plan of correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal law.* 8/17/20 MK (Initials) **F 880** **Corrective action for residents found to have been affected by this deficiency:** No specific residents identified- not applicable Arizona Department of Health Services Division of Public Health Licensing AUG 19 2020 Reception Desk 150 N. 18th Ave #440 Phoenix, AZ 85007	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike
TITLE: ADMINISTRATOR
(X6) DATE: 08/10/2020

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 _____	C 07/02/2020

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 880	Continued From page 1 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility documentation, review of the Center for Disease Control (CDC) guidelines and policies and procedures, the facility failed to maintain an effective infection control program, by having	F 880	**Corrective action for residents that may be affected by the deficiency:** All residents may be affected. The facility immediately changed the entrance for all staff to enter into the front entrance only. The facility implemented that a screener be present at the front desk to let staff members into the facility (all doors locked), and to immediately screen each staff member coming into the facility, and the screeners were in-serviced on the screening process, along with the signs and symptoms of Covid-19. An exception log for symptoms of chronic condition was implemented and exceptions for a chronic condition symptom allowing for work can only be approved by the IP or DNS. An Immediate Jeopardy removal plan was submitted and approved by ADHS on July 2, 2020. A separate Covid-19 unit entrance was established, and the nurse on-duty will screen any employee coming in to work for Covid-19 symptoms.	8/17/20

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 _____	C 07/02/2020

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 880	Continued From page 2 multiple staff who were either symptomatic and positive for COVID-19 or exhibited symptoms of COVID-19 and provided care to residents. As a result, the Condition of Immediate Jeopardy (IJ) was identified. Findings include: On July 1, 2020 at 1:30 p.m., the Condition of Immediate Jeopardy (IJ) was identified. The Administrator (staff #42) was informed of the facility's failure to implement infection control procedures, as multiple staff (#12, #15, #17, #21, #9, #73 and #70) who were either symptomatic (coughing, sore throat, muscle pain, headache) or who were positive for COVID-19 and symptomatic, and were permitted to work with non COVID and COVID positive residents. The Administrator presented a plan of correction on July 1, 2020 at 3:29 p.m. At 3:46 p.m., the Administrator was informed that the plan of correction needed to address additional processes, in order to correct the identified concerns. A revised plan of correction was presented on July 1, 2020 at 5:30 p.m. and was accepted at 6:13 p.m. The plan of correction included for re-education of staff regarding being sent home immediately if they reported signs or symptoms of COVID-19 at the beginning of their shift, or if they developed symptoms at any time during their shift. Staff would also receive in-service education regarding the up-dated screening process, which included having a designated employee assigned to screen staff at the start of their shift. The plan further included that the facility would continue to monitor and track staff	F 880	**Measures that will be put into place to ensure that this deficiency does not recur:** All staff were re-inserviced on signs and symptoms of Covid-19 and inserviced on the new staff entrance and screening process, and prohibition of working with any symptoms of Covid-19. Staff were in-serviced on the Covid unit entrance and screening process. A new Staffing Coordinator has been hired and starts 8-10-2020. A new Director of Nursing has been hired and starts 8-17-2020. The RN ADON is serving as acting DNS. Agency staff through contracts are currently working at the facility. Current staff are being Covid recovered and facility continues to actively recruit and hire. Any Covid positive staff member working with Covid positive residents only, will have to sign an attestation of no symptoms. Any Covid positive staff member will have to have written documentation and signed by the Infection Preventionist or the DNS on a Covid Recovered form, before being scheduled to work. A Directed Inservice by an approved ADHS contractor for all staff on Covid-19 and infection control measures was held on 8-6-2020.	8/17/20

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 _____	C 07/02/2020

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 880	Continued From page 3 symptoms and testing results on a line listing daily, and that the implementation of staffing mitigation strategies would be put into place to address any staffing shortages. On July 1, 2020 between 6:20-6:45 p.m., multiple staff were interviewed regarding if education had been provided pertaining to whether or not symptomatic staff were permitted to work in the facility, and the updated staff screening process. Only one of six staff members understood that symptomatic staff would not be allowed to work with residents and would be sent home. None of the staff interviewed were aware of any changes to the screening process. The Administrator was informed that the facility was not compliant with implementing their plan of correction and inservice's were initiated. On July 2, 2020 between 9:00-10:00 a.m., additional interviews were conducted with facility staff regarding the implementation of their plan of correction. Staff reported that in-services were conducted on handwashing, and donning and doffing Personal Protective Equipment (PPE), however, they had not been educated regarding the revised screening process, and staff did not have an understanding that they would be sent home if they were symptomatic for COVID-19. In addition, review of the staff screening sheets for July 2, 2020 revealed that ten staff members had documented the presence of symptoms and had been permitted to work. Only one of the ten staff members with symptoms had been sent home. In interviews with staff conducted on July 2, 2020, multiple staff reported there had been no designated individual to provide screening for staff entering the COVID unit that morning.	F 880	All staff were in- serviced on the updated process for making changes to the screening logs. Only answer yes or no. If the screener makes a mistake, the screener is to mark one line through it, initial it and mark the correct box, before the employee or visitor signs the screening log. No staff member is to otherwise alter any screening log. If a staff member answers yes to a symptom they will be sent home immediately, unless it is related to a chronic condition and the exception log is completed. The Infection Preventionist is the only staff member allowed to approve an exception. The screening logs are audited and monitored on a daily basis by the Infection Preventionist and Administrator. The logs are signed by the IP and Administrator on the exception report attached to the front desk employee and visitor logs showing the logs have been audited, and on the actual employee screening logs for the Covid Unit. The IP maintains possession of all screening logs.	8/17/20

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 _____	C 07/02/2020

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 880	Continued From page 4 On July 2, 2020 at 12:45 p.m., the Administrator was notified that the plan of correction needed to specifically address staff education to include the following: staff who were symptomatic were to be sent home and would not care for residents; the process for asymptomatic COVID positive staff to return to work, and that staffing mitigation strategies were in place and being implemented in the facility. The plan of correction also needed to include specific details of which staff members would be designated to screen staff during the week and on weekends/holidays, and which staff members would review and follow up on the screening results for staff who documented the presence of symptoms. A revised plan of correction was presented on July 2, 2020 at 1:35 p.m. At 3:26 p.m., The Administrator was informed that the plan of correction needed to address additional areas. On July 2, 2020 at 3:48 p.m., a revised plan of correction was presented. At 4:26 p.m., additional revisions were requested to include who would be responsible for reviewing the employee data collected on the screenings each shift and following up to ensure that symptomatic staff were sent home and removed from caring for residents, and if symptoms were consistent with the employee's baseline, documentation would be completed with detailed information before the employee would be permitted to work. This criterion was to pertain to all staff, whether entering the building through the front door or entering through the COVID unit. A revised plan of correction was presented on July 2, 2020 at 5:10 p.m. and was accepted.	F 880	**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:** Daily audits of staff screening logs for potential Covid-19 symptomatic staff working will be done by the Infection Preventionist and Administrator signing the Covid unit logs, and the exception report attached to the general staff screening logs indicating the logs were audited. Audits will be done daily for two months, then weekly for two months, then monthly for two months to assure continued compliance. Findings and analysis will be reported to the facility's QAA Committee monthly. Responsible: Infection Preventionist and Administrator	8/17/20

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 _____	C 07/02/2020

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 880	Continued From page 5	F 880		

Multiple observations were conducted in the afternoon on July 2, 2020, of the facility implementing their plan of correction. Staff in-services were being completed and staff interviewed were knowledgeable of infection control procedures, including that symptomatic staff would not be permitted to work with residents on any unit. In addition, a designated staff member conducted the screenings, as staff arrived for their shifts.

As the facility was implementing their plan of correction and staff were knowledgeable about the new processes that had been put into place, and there were no additional concerns identified, the Condition of Immediate Jeopardy was abated at 5:15 p.m. on July 2, 2020.

Regarding staff who were symptomatic and/or were symptomatic and had tested positive for COVID-19, and provided care to non-COVID and COVID residents:

-An entrance conference was conducted on June 30, 2020 at 9:10 a.m., with the Administrator and the Director of Nursing (DON/staff #1). The DON stated that the current census was 68. The DON also stated there had been a staffing shortage and they were currently in emergency mode for staffing.

During the survey, an interview was conducted with direct care staff (staff #12), who stated they had received prior in-services regarding COVID-19 about being screened daily for signs and symptoms of illness. Staff #12 stated they were told that if they had three or more symptoms they would be sent home. Staff #12 stated that symptoms began on June...2020, which included

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 _____	C 07/02/2020

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 880	Continued From page 6 a sore throat, cough, muscle aches, fatigue and a headache, and that he/she was tested for COVID-19. He/she said the staffing coordinator (staff #23) was told on June...2020 that he/she was having symptoms (cough, muscle pain, headache and sore throat) and asked not to work. Staff #12 stated that staff #23 said he/she was on the schedule and needed to come to work. Staff #12 stated that he/she worked that day and was screened by staff #23. Staff #12 said that staff #23 completed the documentation on the log. Staff #12 said that he/she told staff #23 that his/her symptoms were cough, muscle pain, headache and sore throat, but was sent out to work on a non-COVID unit that day. Staff #12 said that after the shift was over, he/she went for the exit screening but no one there to screen, so he/she looked at the screening log (from earlier that day) and there was a circle around the symptom of cough and a small question mark had been written next to it. Staff #12 stated the "yes" answer to muscle pain had also been scribbled out and the "no" answer had been checked instead, and there was a circle around the "yes" answer for headache. Review of the corresponding staff screening log for staff #12 for the day referred to in the above interview revealed the following: a question mark had been written next to the symptom of cough; the answer regarding muscle pain was "yes" but it had been scribbled out and a "no" had been marked; for headache the answer was "yes" but a circle had been drawn around "yes" and the symptom of sore throat had both the "yes" and the "no" boxes checked and both had been scribbled out. In the signature screener section, staff #23 (staffing coordinator) had signed her name.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 7	F 880		

Review of the punch detail record for that date revealed that staff #12 worked a full shift.

Continued in the interview staff #12 stated that the next day while being screened, he/she reported symptoms which included a cough, muscle pain, headache and sore throat, but was sent to work on a non-COVID unit again. Staff #12 stated that once on the unit, he/she reported to the nurse about feeling sick, so the nurse called the Assistant Director of Nursing (ADON/staff #33). Staff #12 stated the staffing coordinator (staff #23) texted back and said to stay and work the shift, and text her every two hours to report his/her symptoms, which he/she did.

The corresponding staff screening log for staff #12 included "yes" answers for cough, muscle pain, headache and sore throat.

Review of the punch detail record for this same day revealed that staff #12 worked a full shift.

Staff #12 further stated that the following day (June...2020) he/she also developed diarrhea and vomiting and called off sick. He/she said the next day, a text was received from staff #23 saying that he/she was on the schedule to work that afternoon/evening. Staff #12 stated that he/she texted staff #23 saying he/she still felt sick and staff #23 texted her back and said to get some rest, because he/she needed to be there. Staff #12 stated that he/she worked that afternoon/evening on a COVID unit. Staff #12 said that during the shift, he/she had another episode of diarrhea and reported it to staff #23 via text and asked to go home, but staff #23 said no,

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 _____	C 07/02/2020

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 880	Continued From page 8	F 880		

as there was no one to work the hall.

Review of the staff screening log for staff #12 on that day revealed that both "yes" and "no" were marked for cough, muscle pain and headache and that sore throat was marked "no" and diarrhea and vomiting was marked "yes." In the signature screener section, staff #23 had signed her name.

The punch detail report for this date revealed that staff #12 had worked a full shift.

In the interview, staff #12 further stated the next day (June...2020) he/she called off sick and went to urgent care. They did another COVID test because the results from the facility were not back yet. He/she said the physician from the urgent care told her to go home and quarantine. Staff #12 stated that he/she texted staff #23 the next day on June...2020 and told her that he/she had no taste or smell, and that urgent care said to self-quarantine. Staff #12 also stated that he/she emailed the doctor's note from urgent care to the Human Resource representative (staff #11). Staff #12 said that same day on June...2020, the Administrator said he/she had tested positive for COVID. Staff #12 said the Administrator asked if he/she was symptomatic and responded yes, and had been for a while. Staff #12 stated the Administrator said that asymptomatic COVID positive staff could work on the COVID positive unit. Staff #12 stated the Administrator also said they could make an exception for staff and to keep them informed of his/her symptoms. Staff #12 said the next day on June...2020, he/she texted staff #23 and told her that he/she had tested positive for COVID. Staff #12 stated that staff #23 said he/she was scheduled to work that

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 _____	C 07/02/2020

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 880	Continued From page 9	F 880		

day and was expected to come in. Staff #12 said that he/she told staff #23 that he/she was still symptomatic and was not working sick.

-During the survey, an interview was conducted with direct care staff (staff #17). Staff #17 stated that multiple symptomatic/COVID positive staff members including his/herself have worked with non COVID residents.

A follow-up interview was conducted with staff #17. Staff #17 stated that on June...2020, he/she was tested for COVID-19, along with other staff. Staff #17 said a few days later, he/she developed a fever of 100.2 degrees F, congestion, sore throat, body aches and a cough, and was scheduled to work that day. Staff #17 said that he/she texted the staffing coordinator (staff #23) and told her that he/she did not feel good and she would try to find someone else to cover his/her shift. Staff #17 stated that he/she did not hear back, so he/she went into work that day. Staff #17 stated that after he/she was screened that day, he/she spoke with the staffing coordinator (staff #23) and the DON (staff #1) about being sick. Staff #17 stated that despite his/her symptoms, staff #23 and the DON told him/her to work the floor. Staff #17 stated that he/she was sweating and weak during the shift and texted the staffing coordinator that he/she felt terrible and asked for a replacement. Staff #17 said the staffing coordinator never responded back and he/she worked over an 8 hour shift that day on a non-COVID unit.

Review of the corresponding staff screening log for that day when he/she worked over an 8 hour shift, revealed that staff #17 had a fever of 100.2 degrees F, a cough, muscle pain and a

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 _____	C 07/02/2020

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 880	Continued From page 10	F 880		

headache. The log also included that a temperature greater than or equal to 100.0 degrees F was considered out of the acceptable range.

Review of the punch detail record for this same date revealed that staff #17 worked over 8 hours.

In the interview, staff #17 further stated after that he/she was sick for a few days and that the test results came back negative. Staff #17 said that he/she was still intermittently symptomatic and had a cough, and had not been retested. Staff #17 stated that today he/she worked on a non-COVID unit.

-During the survey, an interview was conducted with a direct care staff member (staff #15). Staff #15 stated he/she started having a cough, sore throat and fever of 101 degrees F a couple of weeks ago and didn't work. Staff #15 said that he/she returned to work a couple of days later on June...2020 and since then, has continued to work with a cough, sore throat and intermittent fever. Staff #15 stated that he/she has not been tested for COVID-19.

A follow-up interview was conducted with staff #15, who stated that he/she continues to have a cough, congestion and headaches. Staff #15 said that yesterday, he/she was asked to stay until registry staff arrived, and worked on both the COVID and non-COVID units.

Review of the staff screening logs for June 2020 through July 2, 2020 revealed that staff #15 had reported various symptoms on multiple days, which included the following: a cough, fever, muscle pain, headache, sore throat or shortness

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 _____	C 07/02/2020

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 880	Continued From page 11	F 880		

of breath. On one day in June, staff #15 had reported shortness of breath, cough and a headache, and the original screening temperature was illegible, as it had been scribbled out and replaced with "99."

According to the corresponding punch detail reports, staff #15 worked on those days in June and July when exhibiting symptoms.

-During the survey, an interview was conducted with direct care staff (staff #21), who stated that on June...2020 he/she began having a headache, body aches, sore throat and chills. Staff #21 stated that he/she texted the staffing coordinator (staff #23), the Administrator and the DON to report his/her symptoms, but no one responded back. The next day, staff #21 said he/she had a fever of 100.3 degrees F, a headache, muscle pains, sore throat, chills and a cough. Staff #21 said he/she was told by staff #23 that he/she was still expected to work his/her shift that day and then worked on the COVID unit.

Review of the corresponding staff screening log for that day when he/she had a fever of 100.3 and other symptoms, revealed that staff #21 had reported muscle pain, headache, sore throat and chills, when she reported to work that day.

Continued in the interview, staff #21 said that a couple of days later he/she worked on a non COVID unit, but was sent home early, because of not feeling well.

Review of the corresponding staff screening log for that day revealed that staff #21 had reported having a cough, fever, muscle pain, headache, sore throat and chills.

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 _____	C 07/02/2020

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 880	Continued From page 12	F 880		

The punch detail record for that date revealed that staff #21 had worked a short time that day.

During the interview, staff #21 further stated that the next day June...2020, he/she worked on a non-COVID unit and still wasn't feeling well.

Review of the corresponding staff screening log for that day revealed that staff #21 reported symptoms which included cough, fever, muscle pain, headache and sore throat.

The punch detail record for that same day included that staff #21 worked a full shift.

Continued in the interview staff #21 stated that a few days later on June...2020, he/she worked on a non-COVID unit again and was short of breath and didn't feel well. Later that afternoon, staff #21 said he/she was told by the Administrator that he/she had tested positive for COVID-19. Staff #21 stated that per the staffing coordinator, the DON and the Administrator, all COVID positive staff still needed to report to work, because that was the facility's policy. Later that same day while working, he/she texted the staffing coordinator (staff #23), the DON and the Administrator that he/she was short of breath and his/her oxygen saturation level was 88% (normal oxygen saturation level is 95-100%). Staff #21 stated that staff #23 said they did not have anyone to replace him/her and that he/she was still on the schedule for the next day June...2020.

Review of the corresponding staff screening log for the day that he/she was notified of the positive test results for COVID, revealed that staff #21 had a cough, muscle pain, a sore throat, and for

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 _____	C 07/02/2020

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 880	Continued From page 13	F 880		

chills it was marked both "yes" and "no."

The punch detail record for that same day included that staff #21 worked a full shift.

In the interview, staff #21 also stated that the next day he/she had a physician visit who told him/her to immediately go to the emergency room. Staff #21 said he/she texted the staffing coordinator, the DON and the Administrator and told them what the physician said and sent them a copy of the doctor's note. Staff #21 said he/she received a text from staff #23 stating that he/she needed him/her to show up for work that day. Staff #21 stated that he/she went to work as scheduled, so the next shift could be relieved. Staff #21 stated that he/she told them that they needed to find someone to take over in a couple of hours. Staff #21 stated that around noon that day, he/she texted the staffing coordinator, the DON and the Administrator and asked for someone to relieve him/her, because it hurt to breathe. Staff #21 stated the Administrator texted back saying they were trying to get someone in to relieve him/her. Staff #21 stated they never called him/her back and he/she ended up working a 12 hour shift on a non-COVID unit.

Review of the corresponding staff screening logs revealed there was no screening documentation for staff #21 for that day.

Review of the punch detail record for that same day revealed that staff #21 worked approximately 12 hours.

On June 30, 2020 at 11:25 a.m., an interview was conducted with the DON (staff #1). He stated that if staff tested positive for COVID-19 but were well

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 _____	C 07/02/2020

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 880	Continued From page 14	F 880		

enough to work, they may work on the COVID unit. He said if staff are symptomatic they are asked to leave. However, he further stated that if he had to he would allow someone with a cough and fever to work on the COVID unit. He said when staff have asked him what their policy was for coming to work with symptoms, he referred them to the Human Resources representative (staff #11), because she was more familiar with that policy.

An interview was conducted on July 1, 2020 at 1:37 p.m., with the Human Resource representative (staff #11). She stated that her understanding of the facility screening process included that if a staff member triggered 2-3 symptoms, they would need to consult with the DON and the Administrator for further screening. She said she believed that staff were switched to two 12 hour shifts to prevent a staffing shortage. She stated she would not consider the facility to have a staffing shortage. She stated that she knows what the CDC has recommended. She said her understanding is if staff have been exposed to COVID-19 but have no symptoms, they would be screened, and allowed to work if they wore a face mask and all the appropriate PPE. She stated if a symptomatic staff member were referred to her, she would review the CDC guidelines which states that the staff member would need to be tested and to isolate, until the results are received. She said if staff came to her to ask about the facility's policy regarding working, she would direct them to speak to the DON. She stated that as far as she knows, they aren't forcing anyone with symptoms to work. She stated that COVID positive staff are allowed to work as long as they are asymptomatic, and only on the COVID unit. She said no one has been

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 _____	C 07/02/2020

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 880	Continued From page 15	F 880		

referred to her with any questions about COVID positive symptomatic staff continuing to work. She stated that she has not been made aware that symptomatic staff are working in the facility.

Regarding changes to the staff screening logs:

-Review of the staff screening logs for June 2020 revealed multiple alterations in the form of scribbling over, marking through, writing on top of and/or crossing out of the screening data that had been provided by facility employees which included the following:

June 2 and 3: changes made to one staff's screening
June 4: changes made to three staff's screenings
June 5 and 7: changes made to one staff's screening
June 8: changes made to three staff's screenings
June 9 and 10: changes made to two staff's screenings
June 11: changes made to four staff's screenings
June 12: changes made to four staff's screenings
June 16: changes made to one staff's screening
June 17: changes made to two staff's screenings
June 18 and 19: changes made to three staff's screenings
June 20: changes made to one staff's screening
June 21, 22 and 23: changes made to two staff's screenings
June 24: changes made to six staff's screenings
June 25: changes made to eight staff's screenings
June 26: changes made to four staff's screenings
June 27: changes made to seven staff's screenings

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 _____	C 07/02/2020

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 880	Continued From page 16 June 28: changes made to three staff's screenings June 29: changes made to four staff's screenings June 30: changes made to six staff's screenings July 1: changes made to four staff's screenings July 2: changes made to seven staff's screenings An interview was conducted on June 30, 2020 at 2:19 p.m., with the staffing coordinator (staff #23). She stated that she does all the staffing for the nurses and the CNAs. She stated that she keeps the staff screening logs with her. She stated if an employee screens in with a temperature of 100.4 degrees F or higher or has more than 2-3 symptoms, she screens them further to see if the symptoms are normal for them. She stated that she has never altered the screening documents to make it seem like staff have no symptoms. She stated that staff are screened at the back entrance and that anyone in the facility can be a screener. Another interview was conducted on June 30, 2020 at 2:20 p.m. with staff #23, who stated that she had no idea who may have altered the screening sheets. Staff #23 stated that screeners must initial the logs when completing the screening. Regarding the facility declaration of a staffing emergency: -On June 30, 2020 at 11:25 a.m., an interview was conducted with the DON (staff #1). He said the facility had not reached "critical" staffing levels until 2 or 3 days ago (June 27 or June 28, 2020). He said the facility was looking into CNA waivers.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 17	F 880		

An interview was conducted on June 30, 2020 at 2:20 p.m. with staff #23, who stated that a staffing emergency began on June 29, 2020, which caused the facility to implement 12 hour shifts for nurses and CNAs. Staff #23 stated that a staffing crisis is when the facility is using 100% registry in their building. She said the core staff have been helpful and pitched in, by taking additional shifts and working extra hours. She stated the staff are grateful for their jobs and the hours. She stated that they had 2 nurses resign, due to concerns for their health and the health of their family.

On July 1, 2020 at approximately 12:20 p.m., an interview was completed with the Administrator. The Administrator said that he had not contacted the county himself for information or assistance, but stated that the DON was in contact with a staff member at the county.

Another interview was conducted with the DON on July 1, 2020 at 12:30 p.m. The DON stated that he had been in contact with Epidemiology at the county office to report any new cases and to give facility updates. In a later interview at 3:56 p.m., the DON stated that he also talked to the county regarding the need for personal protective equipment (PPE), and had briefly discussed a waiver for CNAs. He said that he briefly mentioned possibly needing staffing assistance at some point, but acknowledged that there was no follow up to that conversation which occurred around June 23 or June 25, 2020.

A follow up interview was conducted on July 1, 2020 at 4:01 p.m., with the DON. He stated that he and the Administrator began to have conversations about staffing on June 22, 2020. He stated they were not in crisis mode on that

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 _____	C 07/02/2020

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 880	Continued From page 18	F 880		

date, but considered what they would do in the event of a staffing shortage. He said during that week, he asked the Administrator about strategies that they would use if things went bad. The DON said that on June 23 and June 24, 2020, they were still not in "crisis mode" and were still considering their options. He said on June 25, he asked the Administrator that if things went bad, what were they going to do? He said he suggested that they needed to consider transferring residents out to another facility. He said on June 25, he also spoke with the county and briefly discussed the CNA waiver and mentioned the potential need for staffing assistance. The DON said that on June 26, he was more concerned and wondered if they should be reaching out to other facilities. He stated they were not short-staffed that day and they were not in crisis mode. The DON said he had another conversation with the Administrator regarding their crisis staffing plan. He said on June 27, 2020, staff began calling out sick. He said he spoke with the Clinical Resource Liaison to discuss options and about transferring residents out to other facilities, and to reach out to other facilities to get more staff. The DON further stated that on the evening of June 27, 2020, he received the results of the COVID testing for staff which had taken place on June 22, and that multiple staff had tested positive. He said that same evening, they were short staffed. He said he called out to agency staffing, but found they were requesting hazard pay of 1.5 times the normal rate or $5.00 - $10.00 more per hour. He said the Administrator hesitated to hire them based on that factor. He said a staff from another facility came in, and he also called upon existing staff to cover the other two positions. The DON said that on June 28, administrative staff decided to

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 _____	C 07/02/2020

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 880	Continued From page 19	F 880		

implement their "emergency staffing plan" and began having staff work two 12 hour shifts the following day. He said they called their staff that evening to let them know. He said the facility reached crisis or emergency status on June 29, 2020 (one day prior to the survey team entering the building) and that they implemented their emergency staffing plan. He stated he would provide documentation of the efforts that had been made to abate the staffing issues.

A list of actions taken to abate the staffing crisis was presented by the Clinical Director (staff #57) on July 2, 2020 at 3:20 p.m. Beginning June 15, 2020, the documentation included the need for additional nurses had been discussed during a conference call. A conference call dated June 22, 2020, included the need to hire 5 nurses and 5 CNAs. Another phone conversation with corporate was done on June 22, 2020, which included discussing staffing and registry. On June 28, 2020, two area facilities were contacted regarding their ability to house additional residents, but neither of the facilities had room. On June 29, 2020 during a corporate call with the Executive Directors and Resources, the possibility of transferring residents out of the facility was again discussed. Another call on June 29, 2020 with corporate included discussing staffing, registry, and the transfer of residents. Per the documentation, a call was made to a nursing registry service on June 29, 2020, but there were no nurses available. On June 30, 2020, a medical group was contacted and a contract was signed regarding procurement of CNAs and nurses. On July 1, 2020 (the day of the IJ), two other area facilities were contacted regarding their ability to house additional residents, but neither facility had room. Also on

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 _____	C 07/02/2020

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 880	Continued From page 20	F 880		

July 1, 2020, the documentation indicated that contact was made with three nursing registries in an attempt to procure staff and that they were waiting for responses.

According to the documentation, the facility had various discussions regarding staffing issues, however, no action was taken in an attempt to increase staff until June 29 and June 30, when staffing agencies were contacted. In addition, there was no evidence that the facility had reached out to the county for assistance with staffing concerns anytime from June 25 through July 2, 2020.

Review of the Facility Health and Rehabilitation Facility Assessment updated on March 27, 2020, revealed if the facility needs to activate its Emergency Operations Plan, staff may be called back to work additional shifts and staff may be cross trained to help with additional tasks. The assessment included that agency personnel will be employed through contractual agreements and those staff with mild symptoms will be assigned to work with COVID-19 positive residents only. Per the assessment, the COVID-19 residents will be housed in a separate wing with dedicated staff, so that staff are not intermingling, and non-positive staff will work with non-positive residents to the extent possible.

-During the survey, an interview was conducted with direct care staff (staff #9). Staff #9 stated that symptoms consistent with COVID-19 began on June...2020. Staff #9 stated that on that day, he/she told the staffing coordinator (staff # 23) and the DON of the new onset of cough and a sore throat, but was still assigned to work on a non COVID unit. Staff #9 said when screened

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 _____	C 07/02/2020

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 880	Continued From page 21	F 880		

that day, he/she answered "yes" to cough and sore throat. Staff #9 said that he/she was screened by housekeeping staff (staff #91) that day.

During the interview, the screening log for that day was discussed. The log showed that staff #91 had signed the log for screening staff #9 that day. Further review of the log revealed the answers to cough and sore throat were marked "no." Staff #9 said the housekeeping staff (staff #91) must have checked "no."

In an interview with staff #91, she did not recall screening staff #9 on that day.

Continued in the interview, staff #9 stated that a few days later when screened for a shift on June...2020, he/she answered "yes" to the screening questions regarding new onset for headache, sore throat and loss of taste and smell. Staff #9 said there were several employees saying they were having new onset of symptoms, but no one was making a big deal about it. Staff #9 said that another staff member told him/her that they were experiencing many sick staff, so they did not want any call offs. Staff #9 stated on this same day, the Administrator reported that his/her test result was positive for COVID-19, and was reassigned to work on the COVID hall.

Review of the screening log for that day revealed "yes" for headache and sore throat, and for taste and smell a "yes" and a "no" was marked.

-During the survey, an interview was conducted with direct care staff (staff #73). Staff #73 said that he/she was symptomatic (today) but was working, as they had no staff. Staff #73 said

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 _____	C 07/02/2020

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 880	Continued From page 22	F 880		

he/she was originally assigned to a non COVID hall that day, but was moved to a COVID hall.

Review of the screening log for that day revealed that staff #73 answered "yes" to shortness of breath and "yes" to have you had any contact outside of the facility with someone suspected of having or diagnosed with COVID-19.

A follow up interview was conducted with staff #73. Staff #73 said that he/she was sent home today due to answering "yes" to symptoms at screening. Staff #73 said that he/she was experiencing shortness of breath, a headache and muscle aches and that these are the same symptoms that he/she has had for the last month.

The screening log for staff #73 today revealed "yes" answers for shortness of breath, muscle pain, headache and "yes" to have you had any contact outside of the facility with someone suspected of having or diagnosed with COVID-19. Also on the log was a section to document "yes" or "no" for Recommend Advance Screening (DON/ICP/designee). If answered "yes" to shortness of breath or cough or to any two of the remaining symptoms. This section was marked "yes."

Staff #73 further stated that a few days ago, he/she had a test done which was negative. Staff #73 said that his/her temperature that day was 101.5 degrees F and had a headache and shortness of breath.

According to the punch detail, staff #73 did not work that day.

However, the screening log for the following day

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 _____	C 07/02/2020

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 880	Continued From page 23	F 880		

revealed that staff #73 answered "yes" to the symptoms of shortness of breath, cough and headache.

Per the punch detail report, staff #73 worked that day.

The screening log for the next day on June...2020 revealed that staff #73 answered "yes" to shortness of breath, headache and having had contact with someone outside of the facility with suspected of having or diagnosed with COVID-19.

The punch detail report included that staff #73 worked a full shift that day.

-An interview with direct care staff (staff #70) was conducted during the survey. Staff #70 stated that on June...2020, he/she reported not feeling well and was experiencing symptoms of COVID-19. Staff #70 said that he/she was advised to quarantine for 14 days. Staff #70 said a few days later on June...2020, staff #23 said he/she was able to work with symptoms.

Review of the screening log for that day revealed that staff #70 replied "yes" to the symptoms of shortness of breath and cough and had a temperature of 100.9 degrees F.

The punch detail report included that staff #73 worked a full shift that day.

In the interview, staff #70 further stated that a few days later while working, he/she reported to the DON that he/she was very sick. Staff #70 stated that the DON said he would work on it.

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 _____	C 07/02/2020

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 880	Continued From page 24	F 880		

Review of the screening log for that day revealed that staff #70 answered "yes" to shortness of breath, cough and headache.

Staff #70 also said at the end of the shift that same day, the DON said he/she had tested positive for COVID-19, but still needed her to work the following day.

Per the punch detail report, staff #70 worked a full shift the following day.

Regarding the facility screening logs:

Upon reviewing the staff screening logs for the month of June 2020, there were multiple entries with "yes" marked by one or more of the symptoms related to COVID-19 as follows:

Shortness of breath: approximately 74 yes answers
Cough: approximately 162 yes answers
New loss of taste or smell: 4 yes answers
Repeated shaking with chills: 1 yes answer
Muscle pain: approximately 77 yes answers
Headache: approximately 99 yes answers
Sore throat: approximately 68 yes answers
Chills: 11 yes answers
G.I. symptoms (diarrhea, vomiting, nausea): approximately 30 yes answers

The screening logs further included the following:

Regarding having had contact with someone outside the facility with suspected or diagnosed COVID-19 there were 14 yes answers.
Regarding having traveled on a cruise or internationally in the last 14 days there were 4 yes answers.

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 _____	C 07/02/2020

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 880	Continued From page 25 Regarding advance screening by the DON, IP or designee if yes to shortness of breath, cough or any two of the remaining symptoms there were 34 yes answers. The screening logs did not include any follow up that was done for staff who reported having symptoms. An interview was conducted with the staffing coordinator (staff #23) on June 30, 2020 at 2:20 p.m. Staff #23 stated that she does all of the staffing for the nurses and CNAs. Staff #23 said that staff have been getting sicker over the last few days and they have asked some of the staff to pick up extra shifts or stay longer to put in extra hours to help with coverage. She stated they have started to use registry as well, especially for nursing coverage. She said the regular use of registry staff started about a week ago, but registry staff have been in the building on a limited basis for a couple of months. Staff #23 said that things have really fallen apart in the last couple of days. Staff #23 said that staff who have signs or symptoms are sent home. She said if a staff member has a temperature of 100.4 or two of the other signs or symptoms on the screening sheet, they are to be sent home. She said if a staff member answers "yes" to any of the symptoms on the screening sheet, she is to be advised. She said that she will then speak with the staff member and question them to see if the symptoms are new or if they are normal or "baseline" for that staff member. She said that she will also ask them if they have been sick. She stated that if she is not available, the DON, the Infection Preventionist (staff #72), the Administrator or the Assistant Director of Nursing (staff #33) should be contacted by the staff	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 26	F 880		

member or the screener. She said the staff member will be directed as to their eligibility to remain on site or be sent home.

Staff #23 also stated that if a staff member calls out sick, they are to contact her and explain what signs or symptoms they are experiencing. She said if the symptoms are of new onset, she will contact the DON and they will discuss the situation and direct the staff member as to their eligibility to work. She stated that if she cannot be reached, the DON may be contacted directly by the staff member. Staff #23 stated she does not tell anyone that they "have to work." She said that while staff are out sick, they are required to call in twice daily to report symptoms and answer screening questions.

Staff #23 further stated that upon arrival to the building, staff members screen one another before their shift. She said they ask the oncoming staff member if they have any new symptoms, check the appropriate boxes, take their temperature and log it on the sheet. She said that both the screener and the individual being screened in, must sign the sheet. She stated that any staff member can screen someone, as there is not one dedicated screener. She stated that a secondary screening will be done for anyone answering yes to 2 or more symptoms or an elevated temperature. Staff #23 stated that she keeps all of the screening sheets.

In a follow up interview with staff #23 on July 2, 2020 at 2:02 p.m., she said her expectation is that a second screening would be done for any staff member checking yes to 2 or more symptoms on the screening sheet or a temperature of 100.0 degrees F or higher. She

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 _____	C 07/02/2020

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 880	Continued From page 27	F 880		

said that staff may return to work if they have two negative tests 24 hours apart or no fever for 72 hours, without the use of fever reducing medications. She stated that when staff return from sick leave they will be assigned to the COVID-19 unit, unless otherwise specified by the DON. She stated that staff who are asymptomatic but COVID-19 positive, may work on the COVID unit only. She stated that the DON makes the decision if staff can work, but no one is forced to work.

Review of the facility's policy titled, Emerging Infectious Disease Emergency Plan Coronavirus (COVID-2019) dated March 2020, revealed under the section for staffing that during an emergency, the Administer or the Director of Nursing may declare the facility is experiencing an emergency due to COVID-19. This includes calling staff from all departments and directing them to either report for duty immediately or be scheduled for future shifts. All staff may be assigned to full, halftime or overtime shifts and may be scheduled to work on their days off. The policy stated that if staff are ill, have a fever, a cough or respiratory compromise or have other symptoms consistent with a contagious process, they should not present to the facility for regular or emergency duty, unless it is in response to a pandemic outbreak involving the facility itself, such as COVID-19. In that case, if the facility has confirmed cases of COVID-19 and staff that have confirmed or suspected COVID-19 with mild-moderate symptoms, will report to duty to work with only COVID positive residents, who are segregated from other residents and staff. A separate entrance will be made and separate time logs will be kept for those staff members.

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 _____	C 07/02/2020

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 880	Continued From page 28 Review of the CDC guidance titled, Preparing for COVID-19 in Nursing Homes updated June 25, 2020, revealed the facility should screen all healthcare personnel (HCP) at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. The facility should remind HCP to stay home when they are ill. If HCP develops a fever (temperature of 100.0 degrees F) or other symptoms consistent with COVID-19 while at work, they should inform their supervisor and leave the workplace. If they are ill, staff should keep their cloth face covering or facemask on and leave the workplace. The guidance stated that a fever is either a measured temperature greater than 100.0 degrees F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications such as fever reducing medications. HCP with suspected COVID-19 should be prioritized for testing. The CDC guidelines further included to implement sick leave policies that are non-punitive, flexible and consistent with public health policies that support HCP to stay home when ill. The guidelines stated to reinforce sick leave policies and remind HCP not to report to work when ill. In addition, the guidelines stated that facilities should have a plan in place regarding how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers). The guidance also included to develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 29 Review of the CDC guidance regarding Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 dated May 5, 2020 revealed the following: Symptomatic HCP with suspected or confirmed COVID-19 should be excluded from work for at least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of medication to reduce fever and improvement in respiratory symptoms (e.g., cough, shortness of breath); and at least 10 days have passed since symptoms first appeared. The guidance stated that if using a test based strategy, fever must resolve without the use of fever reducing medication, respiratory symptoms such as cough and shortness of breath must improve and 2 negative test results at least 24 hours apart must be documented. Under the section for Strategies to Mitigate HCP Staffing Shortages, it stated that staffing shortages will likely occur due to HCP exposures, illness or need to care for family members at home. Facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them.	F 880		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

August 14, 2020

Receipt Of This Notice Is Presumed To Be 08/14/2020
Important Notice - Please Read Carefully

Mr. Larry Michael Rasmussen, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Rasmussen:

Enclosed please find the Statement of Deficiencies and Plan of Correction for the Complaint Investigation **#9VH211** conducted on July 2, 2020 which was submitted to the Bureau of Long Term Care on August 10, 2020.

The Plan of Correction is unacceptable for the following reasons:

-For F880/Y2205:
-Part of the deficient practice was that there were multiple changes noted to the screening logs in the form of answers being crossed out or both a yes and a no being checked when the form asked if the employee was having a certain symptom of COVID. Include how the process has been updated for how/when changes are made to the log including that staff have been in-serviced on this change and how it will be audited/monitored.

-Provide evidence that staff have been in-serviced on this updated process for making changes to the log.

-Provide evidence showing that this change has been audited/monitored.

-Regarding the current procedure for auditing the screening logs, please clarify the audit process on the 2567. Some of the logs themselves have signatures on them, while others do not. The exception log is always signed. How are these logs being audited and how/what is signed off?

-You may need to adjust the completion date to complete the changes above.

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

The requested documents are required to be returned to this office no later than **August 20, 2020**, please retaining a copy for your files. If the requested documents for the Plan of Correction are not received by this office on or before **August 20, 2020**, licensure action and/or civil penalties may be assessed.

Thank you for your cooperation. If you have any questions, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\MC:mm

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

July 29, 2020

Receipt Of This Notice Is Presumed To Be 07/29/2020
Important Notice - Please Read Carefully

Larry Michael Rasmussen, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr Rasmussen:

Included in this letter are instructions for your Directed Inservice training, must be aproved and completed by August 12, 2020. This inservice training must be done on the following areas of noncompliance which were identified at the time of the complaint survey conducted on July 2, 2020:

- **F-880** Infection Prevention and Control
- **Y2205** Infection Control

The inservice training must be a program developed by sources with an in-depth knowledge of the area(s) which require specific training. Facilities may choose to select:

1. Any training program developed by an established center of geriatric health services education, such as schools in the health sciences, including, but not limited to, medicine, nursing, pharmacy, social work, recreational therapy, occupational therapy, speech pathology, physical therapy, dietetics, and environmental health.

2. A training program provider who has demonstrated expertise in the relevant area, such as through a school in the health sciences, and has developed a training program that meets the criteria for continuing education from the appropriate accrediting body, e.g., the Arizona Nurses Association.

3. A training program provided by an area health education center which has established programs in geriatrics and geriatric psychiatry, centers for aging such as the Area Agency on Aging, or the Ombudsman program, for training in appropriate areas.

Documentation of the completion of the directed inservice training must be submitted to the Long Term Care Bureau Chief or designee by the effective date identified above.

Payment for the directed inservice training is the responsibility of the facility.

Action Following Training: After the staff has received inservice training, if the facility has not achieved substantial compliance, the State may impose one or more other remedies specified in CFR 488.406.

If you have any questions concerning this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles
Bureau Chief

DE\sf

Enclosure

cc: CMS /AHCCCS

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

07/29/2020 (Revised 8-17-2020)

Receipt of Notice Presumed 07/29/2020 via email
Important Notice - Please Read

Larry Michael Rasmussen, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Rasmussen:

On **July 2, 2020** a complaint survey was conducted at your facility by the Department of Health Services, Office 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.

This survey found that your facility was not in substantial compliance with the participation requirements, and the conditions in your facility constituted **Immediate Jeopardy** to resident health or safety.

On **July 1, 2020/1:30 p.m.**, immediate jeopardy to resident health and safety was identified.
The immediate jeopardy to resident health and safety was removed on **July 2, 2020/5:15 p.m.**

Plan of Correction (POC)

A Plan of Correction (PoC) for the deficiencies must be submitted by 08/10/2020. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by 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 the facility 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 will the facility make to ensure that the deficient practice does not recur;

- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and

- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

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

Allegation of Compliance

Your properly signed Plan of Correction constitutes your credible allegation of compliance. If upon the subsequent revisit, your facility has not achieved substantial compliance, a civil money penalty may be imposed by the CMS Regional Office or State Medicaid Agency beginning on **08/16/20** and continuing until substantial compliance is achieved. The CMS Regional Office or State Medicaid Agency may also impose additional remedies or revise remedies at that time if appropriate.

Recommended Remedies

The remedies which will be recommended for imposition are the following:

- **Civil money penalty per (day/instance), effective 08/16/20 (§488.430).**
- **Directed In-Service Training for tag F880 - Infection Prevention and Control.**
- **Recommending to CMS Denial of Payment for New Admissions.**

We are also recommending to the CMS Regional Office that your provider agreement be terminated on **12/29/20**, if substantial compliance is not achieved by that time.

If the Regional Office or the State Medicaid Agency decides to impose the recommended civil money penalty, a notice of imposition will be sent to you. The penalty will continue to accrue until the deficiencies are corrected and your facility is found to be in substantial compliance, or your provider agreement is terminated.

Termination effective **12/29/20** (§488.456).

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 **9/30/20**. 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 **09/30/20.**

Loss of Nurse Aide Program

Please note that Federal law, as specified in the Social Security Act at sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by or in a facility which within the previous two years has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver; has been subject to an extended or partial extended survey; has been assessed a civil money penalty of not less than $5,000.00; or, has been subject to a denial of payment, the appointment of a temporary manager, termination, or, in the case of an emergency, been closed and/or had its residents transferred to other facilities. As a result of , this provision is applicable to your facility and you will receive further notification from the state.

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, and an explanation of why you are disputing those deficiencies, along with supporting information that shows the facility was in compliance at the time of the survey. Send this documentation to Diane Eckles, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. This request must be sent by August 7, 2020 the same time 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: Effective July 1, 2007, facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.

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.

A change in the seriousness of the deficiencies to non-immediate jeopardy may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

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

Diane Eckles,
Bureau Chief

DE:sf
Enclosure
cc: CMS Regional Office + SOD
State Medicaid Agency + SOD

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 _____	C 07/02/2020

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 investigation of Complaint #AZ00165552 was conducted from June 30, 2020 through July 2, 2020. The following deficiency was cited:	F 000	*This plan of correction is the facility's credible allegation of compliance.*	
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880	*Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal law.* mr (Initials) 8/7/2020 **F 880** **Corrective action for residents found to have been affected by this deficiency:** No specific residents identified- not applicable Arizona Department of Health Division of Public Health Licensing Services AUG 10 2020 Reception Desk 150 N. 18th Ave #400 Phoenix, AZ 85007	

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

Administrator 8/10/2020

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 _____	C 07/02/2020

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 880	Continued From page 1 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility documentation, review of the Center for Disease Control (CDC) guidelines and policies and procedures, the facility failed to maintain an effective infection control program, by having	F 880	**Corrective action for residents that may be affected by the deficiency:** All residents may be affected. The facility immediately changed the entrance for all staff to enter into the front entrance only. The facility implemented that a screener be present at the front desk to let staff members into the facility (all doors locked), and to immediately screen each staff member coming into the facility, and the screeners were in-serviced on the screening process, along with the signs and symptoms of Covid-19. An exception log for symptoms of chronic condition was implemented and exceptions for a chronic condition symptom allowing for work can only be approved by the IP or DNS. An Immediate Jeopardy removal plan was submitted and approved by ADHS on July 2, 2020. A separate Covid-19 unit entrance was established, and the nurse on-duty will screen any employee coming in to work for Covid-19 symptoms.	7/7/2020

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 _____	C 07/02/2020

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 880	Continued From page 2 multiple staff who were either symptomatic and positive for COVID-19 or exhibited symptoms of COVID-19 and provided care to residents. As a result, the Condition of Immediate Jeopardy (IJ) was identified. Findings include: On July 1, 2020 at 1:30 p.m., the Condition of Immediate Jeopardy (IJ) was identified. The Administrator (staff #42) was informed of the facility's failure to implement infection control procedures, as multiple staff (#12, #15, #17, #21, #9, #73 and #70) who were either symptomatic (coughing, sore throat, muscle pain, headache) or who were positive for COVID-19 and symptomatic, and were permitted to work with non COVID and COVID positive residents. The Administrator presented a plan of correction on July 1, 2020 at 3:29 p.m. At 3:46 p.m., the Administrator was informed that the plan of correction needed to address additional processes, in order to correct the identified concerns. A revised plan of correction was presented on July 1, 2020 at 5:30 p.m. and was accepted at 6:13 p.m. The plan of correction included for re-education of staff regarding being sent home immediately if they reported signs or symptoms of COVID-19 at the beginning of their shift, or if they developed symptoms at any time during their shift. Staff would also receive in-service education regarding the up-dated screening process, which included having a designated employee assigned to screen staff at the start of their shift. The plan further included that the facility would continue to monitor and track staff	F 880	**Measures that will be put into place to ensure that this deficiency does not recur:** All staff were re-inserviced on signs and symptoms of Covid-19 and inserviced on the new staff entrance and screening process, and prohibition of working with any symptoms of Covid-19. Staff were in-serviced on the Covid unit entrance and screening process. A new Staffing Coordinator has been hired and starts 8-10-2020. A new Director of Nursing has been hired and starts 8-17-2020. The RN ADON is serving as acting DNS. Agency staff through contracts are currently working at the facility. Current staff are being Covid recovered and facility continues to actively recruit and hire. Any Covid positive staff member working with Covid positive residents only, will have to sign an attestation of no symptoms. Any Covid positive staff member will have to have written documentation and signed by the Infection Preventionist or the DNS on a Covid Recovered form, before being scheduled to work. A Directed Inservice by an approved ADHS contractor for all staff on Covid-19 and infection control measures was held on 8-6-2020.	8/7/2020

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 _____	C 07/02/2020

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 880	Continued From page 3 symptoms and testing results on a line listing daily, and that the implementation of staffing mitigation strategies would be put into place to address any staffing shortages. On July 1, 2020 between 6:20-6:45 p.m., multiple staff were interviewed regarding if education had been provided pertaining to whether or not symptomatic staff were permitted to work in the facility, and the updated staff screening process. Only one of six staff members understood that symptomatic staff would not be allowed to work with residents and would be sent home. None of the staff interviewed were aware of any changes to the screening process. The Administrator was informed that the facility was not compliant with implementing their plan of correction and inservice's were initiated. On July 2, 2020 between 9:00-10:00 a.m., additional interviews were conducted with facility staff regarding the implementation of their plan of correction. Staff reported that in-services were conducted on handwashing, and donning and doffing Personal Protective Equipment (PPE), however, they had not been educated regarding the revised screening process, and staff did not have an understanding that they would be sent home if they were symptomatic for COVID-19. In addition, review of the staff screening sheets for July 2, 2020 revealed that ten staff members had documented the presence of symptoms and had been permitted to work. Only one of the ten staff members with symptoms had been sent home. In interviews with staff conducted on July 2, 2020, multiple staff reported there had been no designated individual to provide screening for staff entering the COVID unit that morning.	F 880	**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:** Daily audits of staff screening logs for potential Covid-19 symptomatic staff working will be done by the Infection Preventionist and Administrator for two months, then weekly for two months, then monthly for two months to assure continued compliance. Findings and analysis will be reported to the facility's QAA Committee monthly. Responsible: Infection Preventionist and Administrator	8/7/2020

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 _____	C 07/02/2020

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 880	Continued From page 4 On July 2, 2020 at 12:45 p.m., the Administrator was notified that the plan of correction needed to specifically address staff education to include the following: staff who were symptomatic were to be sent home and would not care for residents; the process for asymptomatic COVID positive staff to return to work, and that staffing mitigation strategies were in place and being implemented in the facility. The plan of correction also needed to include specific details of which staff members would be designated to screen staff during the week and on weekends/holidays, and which staff members would review and follow up on the screening results for staff who documented the presence of symptoms. A revised plan of correction was presented on July 2, 2020 at 1:35 p.m. At 3:26 p.m., The Administrator was informed that the plan of correction needed to address additional areas. On July 2, 2020 at 3:48 p.m., a revised plan of correction was presented. At 4:26 p.m., additional revisions were requested to include who would be responsible for reviewing the employee data collected on the screenings each shift and following up to ensure that symptomatic staff were sent home and removed from caring for residents, and if symptoms were consistent with the employee's baseline, documentation would be completed with detailed information before the employee would be permitted to work. This criterion was to pertain to all staff, whether entering the building through the front door or entering through the COVID unit. A revised plan of correction was presented on July 2, 2020 at 5:10 p.m. and was accepted.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 5 Multiple observations were conducted in the afternoon on July 2, 2020, of the facility implementing their plan of correction. Staff in-services were being completed and staff interviewed were knowledgeable of infection control procedures, including that symptomatic staff would not be permitted to work with residents on any unit. In addition, a designated staff member conducted the screenings, as staff arrived for their shifts. As the facility was implementing their plan of correction and staff were knowledgeable about the new processes that had been put into place, and there were no additional concerns identified, the Condition of Immediate Jeopardy was abated at 5:15 p.m. on July 2, 2020. Regarding staff who were symptomatic and/or were symptomatic and had tested positive for COVID-19, and provided care to non-COVID and COVID residents: -An entrance conference was conducted on June 30, 2020 at 9:10 a.m., with the Administrator and the Director of Nursing (DON/staff #1). The DON stated that the current census was 68. The DON also stated there had been a staffing shortage and they were currently in emergency mode for staffing. During the survey, an interview was conducted with direct care staff (staff #12), who stated they had received prior in-services regarding COVID-19 about being screened daily for signs and symptoms of illness. Staff #12 stated they were told that if they had three or more symptoms they would be sent home. Staff #12 stated that symptoms began on June...2020, which included	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 7 Review of the punch detail record for that date revealed that staff #12 worked a full shift. Continued in the interview staff #12 stated that the next day while being screened, he/she reported symptoms which included a cough, muscle pain, headache and sore throat, but was sent to work on a non-COVID unit again. Staff #12 stated that once on the unit, he/she reported to the nurse about feeling sick, so the nurse called the Assistant Director of Nursing (ADON/staff #33). Staff #12 stated the staffing coordinator (staff #23) texted back and said to stay and work the shift, and text her every two hours to report his/her symptoms, which he/she did. The corresponding staff screening log for staff #12 included "yes" answers for cough, muscle pain, headache and sore throat. Review of the punch detail record for this same day revealed that staff #12 worked a full shift. Staff #12 further stated that the following day (June...2020) he/she also developed diarrhea and vomiting and called off sick. He/she said the next day, a text was received from staff #23 saying that he/she was on the schedule to work that afternoon/evening. Staff #12 stated that he/she texted staff #23 saying he/she still felt sick and staff #23 texted her back and said to get some rest, because he/she needed to be there. Staff #12 stated that he/she worked that afternoon/evening on a COVID unit. Staff #12 said that during the shift, he/she had another episode of diarrhea and reported it to staff #23 via text and asked to go home, but staff #23 said no,	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 8 as there was no one to work the hall. Review of the staff screening log for staff #12 on that day revealed that both "yes" and "no" were marked for cough, muscle pain and headache and that sore throat was marked "no" and diarrhea and vomiting was marked "yes." In the signature screener section, staff #23 had signed her name. The punch detail report for this date revealed that staff #12 had worked a full shift. In the interview, staff #12 further stated the next day (June...2020) he/she called off sick and went to urgent care. They did another COVID test because the results from the facility were not back yet. He/she said the physician from the urgent care told her to go home and quarantine. Staff #12 stated that he/she texted staff #23 the next day on June...2020 and told her that he/she had no taste or smell, and that urgent care said to self-quarantine. Staff #12 also stated that he/she emailed the doctor's note from urgent care to the Human Resource representative (staff #11). Staff #12 said that same day on June...2020, the Administrator said he/she had tested positive for COVID. Staff #12 said the Administrator asked if he/she was symptomatic and responded yes, and had been for a while. Staff #12 stated the Administrator said that asymptomatic COVID positive staff could work on the COVID positive unit. Staff #12 stated the Administrator also said they could make an exception for staff and to keep them informed of his/her symptoms. Staff #12 said the next day on June...2020, he/she texted staff #23 and told her that he/she had tested positive for COVID. Staff #12 stated that staff #23 said he/she was scheduled to work that	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 9 day and was expected to come in. Staff #12 said that he/she told staff #23 that he/she was still symptomatic and was not working sick. -During the survey, an interview was conducted with direct care staff (staff #17). Staff #17 stated that multiple symptomatic/COVID positive staff members including his/herself have worked with non COVID residents. A follow-up interview was conducted with staff #17. Staff #17 stated that on June...2020, he/she was tested for COVID-19, along with other staff. Staff #17 said a few days later, he/she developed a fever of 100.2 degrees F, congestion, sore throat, body aches and a cough, and was scheduled to work that day. Staff #17 said that he/she texted the staffing coordinator (staff #23) and told her that he/she did not feel good and she would try to find someone else to cover his/her shift. Staff #17 stated that he/she did not hear back, so he/she went into work that day. Staff #17 stated that after he/she was screened that day, he/she spoke with the staffing coordinator (staff #23) and the DON (staff #1) about being sick. Staff #17 stated that despite his/her symptoms, staff #23 and the DON told him/her to work the floor. Staff #17 stated that he/she was sweating and weak during the shift and texted the staffing coordinator that he/she felt terrible and asked for a replacement. Staff #17 said the staffing coordinator never responded back and he/she worked over an 8 hour shift that day on a non-COVID unit. Review of the corresponding staff screening log for that day when he/she worked over an 8 hour shift, revealed that staff #17 had a fever of 100.2 degrees F, a cough, muscle pain and a	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 10 headache. The log also included that a temperature greater than or equal to 100.0 degrees F was considered out of the acceptable range. Review of the punch detail record for this same date revealed that staff #17 worked over 8 hours. In the interview, staff #17 further stated after that he/she was sick for a few days and that the test results came back negative. Staff #17 said that he/she was still intermittently symptomatic and had a cough, and had not been retested. Staff #17 stated that today he/she worked on a non-COVID unit. -During the survey, an interview was conducted with a direct care staff member (staff #15). Staff #15 stated he/she started having a cough, sore throat and fever of 101 degrees F a couple of weeks ago and didn't work. Staff #15 said that he/she returned to work a couple of days later on June...2020 and since then, has continued to work with a cough, sore throat and intermittent fever. Staff #15 stated that he/she has not been tested for COVID-19. A follow-up interview was conducted with staff #15, who stated that he/she continues to have a cough, congestion and headaches. Staff #15 said that yesterday, he/she was asked to stay until registry staff arrived, and worked on both the COVID and non-COVID units. Review of the staff screening logs for June 2020 through July 2, 2020 revealed that staff #15 had reported various symptoms on multiple days, which included the following: a cough, fever, muscle pain, headache, sore throat or shortness	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 11 of breath. On one day in June, staff #15 had reported shortness of breath, cough and a headache, and the original screening temperature was illegible, as it had been scribbled out and replaced with "99." According to the corresponding punch detail reports, staff #15 worked on those days in June and July when exhibiting symptoms. -During the survey, an interview was conducted with direct care staff (staff #21), who stated that on June...2020 he/she began having a headache, body aches, sore throat and chills. Staff #21 stated that he/she texted the staffing coordinator (staff #23), the Administrator and the DON to report his/her symptoms, but no one responded back. The next day, staff #21 said he/she had a fever of 100.3 degrees F, a headache, muscle pains, sore throat, chills and a cough. Staff #21 said he/she was told by staff #23 that he/she was still expected to work his/her shift that day and then worked on the COVID unit. Review of the corresponding staff screening log for that day when he/she had a fever of 100.3 and other symptoms, revealed that staff #21 had reported muscle pain, headache, sore throat and chills, when she reported to work that day. Continued in the interview, staff #21 said that a couple of days later he/she worked on a non COVID unit, but was sent home early, because of not feeling well. Review of the corresponding staff screening log for that day revealed that staff #21 had reported having a cough, fever, muscle pain, headache, sore throat and chills.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 12 The punch detail record for that date revealed that staff #21 had worked a short time that day. During the interview, staff #21 further stated that the next day June...2020, he/she worked on a non-COVID unit and still wasn't feeling well. Review of the corresponding staff screening log for that day revealed that staff #21 reported symptoms which included cough, fever, muscle pain, headache and sore throat. The punch detail record for that same day included that staff #21 worked a full shift. Continued in the interview staff #21 stated that a few days later on June...2020, he/she worked on a non-COVID unit again and was short of breath and didn't feel well. Later that afternoon, staff #21 said he/she was told by the Administrator that he/she had tested positive for COVID-19. Staff #21 stated that per the staffing coordinator, the DON and the Administrator, all COVID positive staff still needed to report to work, because that was the facility's policy. Later that same day while working, he/she texted the staffing coordinator (staff #23), the DON and the Administrator that he/she was short of breath and his/her oxygen saturation level was 88% (normal oxygen saturation level is 95-100%). Staff #21 stated that staff #23 said they did not have anyone to replace him/her and that he/she was still on the schedule for the next day June...2020. Review of the corresponding staff screening log for the day that he/she was notified of the positive test results for COVID, revealed that staff #21 had a cough, muscle pain, a sore throat, and for	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 13 chills it was marked both "yes" and "no." The punch detail record for that same day included that staff #21 worked a full shift. In the interview, staff #21 also stated that the next day he/she had a physician visit who told him/her to immediately go to the emergency room. Staff #21 said he/she texted the staffing coordinator, the DON and the Administrator and told them what the physician said and sent them a copy of the doctor's note. Staff #21 said he/she received a text from staff #23 stating that he/she needed him/her to show up for work that day. Staff #21 stated that he/she went to work as scheduled, so the next shift could be relieved. Staff #21 stated that he/she told them that they needed to find someone to take over in a couple of hours. Staff #21 stated that around noon that day, he/she texted the staffing coordinator, the DON and the Administrator and asked for someone to relieve him/her, because it hurt to breathe. Staff #21 stated the Administrator texted back saying they were trying to get someone in to relieve him/her. Staff #21 stated they never called him/her back and he/she ended up working a 12 hour shift on a non-COVID unit. Review of the corresponding staff screening logs revealed there was no screening documentation for staff #21 for that day. Review of the punch detail record for that same day revealed that staff #21 worked approximately 12 hours. On June 30, 2020 at 11:25 a.m., an interview was conducted with the DON (staff #1). He stated that if staff tested positive for COVID-19 but were well	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 14 enough to work, they may work on the COVID unit. He said if staff are symptomatic they are asked to leave. However, he further stated that if he had to he would allow someone with a cough and fever to work on the COVID unit. He said when staff have asked him what their policy was for coming to work with symptoms, he referred them to the Human Resources representative (staff #11), because she was more familiar with that policy. An interview was conducted on July 1, 2020 at 1:37 p.m., with the Human Resource representative (staff #11). She stated that her understanding of the facility screening process included that if a staff member triggered 2-3 symptoms, they would need to consult with the DON and the Administrator for further screening. She said she believed that staff were switched to two 12 hour shifts to prevent a staffing shortage. She stated she would not consider the facility to have a staffing shortage. She stated that she knows what the CDC has recommended. She said her understanding is if staff have been exposed to COVID-19 but have no symptoms, they would be screened, and allowed to work if they wore a face mask and all the appropriate PPE. She stated if a symptomatic staff member were referred to her, she would review the CDC guidelines which states that the staff member would need to be tested and to isolate, until the results are received. She said if staff came to her to ask about the facility's policy regarding working, she would direct them to speak to the DON. She stated that as far as she knows, they aren't forcing anyone with symptoms to work. She stated that COVID positive staff are allowed to work as long as they are asymptomatic, and only on the COVID unit. She said no one has been	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 15 referred to her with any questions about COVID positive symptomatic staff continuing to work. She stated that she has not been made aware that symptomatic staff are working in the facility. Regarding changes to the staff screening logs: -Review of the staff screening logs for June 2020 revealed multiple alterations in the form of scribbling over, marking through, writing on top of and/or crossing out of the screening data that had been provided by facility employees which included the following: June 2 and 3: changes made to one staff's screening June 4: changes made to three staff's screenings June 5 and 7: changes made to one staff's screening June 8: changes made to three staff's screenings June 9 and 10: changes made to two staff's screenings June 11: changes made to four staff's screenings June 12: changes made to four staff's screenings June 16: changes made to one staff's screening June 17: changes made to two staff's screenings June 18 and 19: changes made to three staff's screenings June 20: changes made to one staff's screening June 21, 22 and 23: changes made to two staff's screenings June 24: changes made to six staff's screenings June 25: changes made to eight staff's screenings June 26: changes made to four staff's screenings June 27: changes made to seven staff's screenings	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 16 June 28: changes made to three staff's screenings June 29: changes made to four staff's screenings June 30: changes made to six staff's screenings July 1: changes made to four staff's screenings July 2: changes made to seven staff's screenings An interview was conducted on June 30, 2020 at 2:19 p.m., with the staffing coordinator (staff #23). She stated that she does all the staffing for the nurses and the CNAs. She stated that she keeps the staff screening logs with her. She stated if an employee screens in with a temperature of 100.4 degrees F or higher or has more than 2-3 symptoms, she screens them further to see if the symptoms are normal for them. She stated that she has never altered the screening documents to make it seem like staff have no symptoms. She stated that staff are screened at the back entrance and that anyone in the facility can be a screener. Another interview was conducted on June 30, 2020 at 2:20 p.m. with staff #23, who stated that she had no idea who may have altered the screening sheets. Staff #23 stated that screeners must initial the logs when completing the screening. Regarding the facility declaration of a staffing emergency: -On June 30, 2020 at 11:25 a.m., an interview was conducted with the DON (staff #1). He said the facility had not reached "critical" staffing levels until 2 or 3 days ago (June 27 or June 28, 2020). He said the facility was looking into CNA waivers.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 17 An interview was conducted on June 30, 2020 at 2:20 p.m. with staff #23, who stated that a staffing emergency began on June 29, 2020, which caused the facility to implement 12 hour shifts for nurses and CNAs. Staff #23 stated that a staffing crisis is when the facility is using 100% registry in their building. She said the core staff have been helpful and pitched in, by taking additional shifts and working extra hours. She stated the staff are grateful for their jobs and the hours. She stated that they had 2 nurses resign, due to concerns for their health and the health of their family. On July 1, 2020 at approximately 12:20 p.m., an interview was completed with the Administrator. The Administrator said that he had not contacted the county himself for information or assistance, but stated that the DON was in contact with a staff member at the county. Another interview was conducted with the DON on July 1, 2020 at 12:30 p.m. The DON stated that he had been in contact with Epidemiology at the county office to report any new cases and to give facility updates. In a later interview at 3:56 p.m., the DON stated that he also talked to the county regarding the need for personal protective equipment (PPE), and had briefly discussed a waiver for CNAs. He said that he briefly mentioned possibly needing staffing assistance at some point, but acknowledged that there was no follow up to that conversation which occurred around June 23 or June 25, 2020. A follow up interview was conducted on July 1, 2020 at 4:01 p.m., with the DON. He stated that he and the Administrator began to have conversations about staffing on June 22, 2020. He stated they were not in crisis mode on that	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 18	F 880		

date, but considered what they would do in the event of a staffing shortage. He said during that week, he asked the Administrator about strategies that they would use if things went bad. The DON said that on June 23 and June 24, 2020, they were still not in "crisis mode" and were still considering their options. He said on June 25, he asked the Administrator that if things went bad, what were they going to do? He said he suggested that they needed to consider transferring residents out to another facility. He said on June 25, he also spoke with the county and briefly discussed the CNA waiver and mentioned the potential need for staffing assistance. The DON said that on June 26, he was more concerned and wondered if they should be reaching out to other facilities. He stated they were not short-staffed that day and they were not in crisis mode. The DON said he had another conversation with the Administrator regarding their crisis staffing plan. He said on June 27, 2020, staff began calling out sick. He said he spoke with the Clinical Resource Liaison to discuss options and about transferring residents out to other facilities, and to reach out to other facilities to get more staff. The DON further stated that on the evening of June 27, 2020, he received the results of the COVID testing for staff which had taken place on June 22, and that multiple staff had tested positive. He said that same evening, they were short staffed. He said he called out to agency staffing, but found they were requesting hazard pay of 1.5 times the normal rate or $5.00 - $10.00 more per hour. He said the Administrator hesitated to hire them based on that factor. He said a staff from another facility came in, and he also called upon existing staff to cover the other two positions. The DON said that on June 28, administrative staff decided to

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 _____	C 07/02/2020

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 880	Continued From page 19	F 880		

implement their "emergency staffing plan" and began having staff work two 12 hour shifts the following day. He said they called their staff that evening to let them know. He said the facility reached crisis or emergency status on June 29, 2020 (one day prior to the survey team entering the building) and that they implemented their emergency staffing plan. He stated he would provide documentation of the efforts that had been made to abate the staffing issues.

A list of actions taken to abate the staffing crisis was presented by the Clinical Director (staff #57) on July 2, 2020 at 3:20 p.m. Beginning June 15, 2020, the documentation included the need for additional nurses had been discussed during a conference call. A conference call dated June 22, 2020, included the need to hire 5 nurses and 5 CNAs. Another phone conversation with corporate was done on June 22, 2020, which included discussing staffing and registry. On June 28, 2020, two area facilities were contacted regarding their ability to house additional residents, but neither of the facilities had room. On June 29, 2020 during a corporate call with the Executive Directors and Resources, the possibility of transferring residents out of the facility was again discussed. Another call on June 29, 2020 with corporate included discussing staffing, registry, and the transfer of residents. Per the documentation, a call was made to a nursing registry service on June 29, 2020, but there were no nurses available. On June 30, 2020, a medical group was contacted and a contract was signed regarding procurement of CNAs and nurses. On July 1, 2020 (the day of the IJ), two other area facilities were contacted regarding their ability to house additional residents, but neither facility had room. Also on

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 _____	C 07/02/2020

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 880	Continued From page 20 July 1, 2020, the documentation indicated that contact was made with three nursing registries in an attempt to procure staff and that they were waiting for responses. According to the documentation, the facility had various discussions regarding staffing issues, however, no action was taken in an attempt to increase staff until June 29 and June 30, when staffing agencies were contacted. In addition, there was no evidence that the facility had reached out to the county for assistance with staffing concerns anytime from June 25 through July 2, 2020. Review of the Facility Health and Rehabilitation Facility Assessment updated on March 27, 2020, revealed if the facility needs to activate its Emergency Operations Plan, staff may be called back to work additional shifts and staff may be cross trained to help with additional tasks. The assessment included that agency personnel will be employed through contractual agreements and those staff with mild symptoms will be assigned to work with COVID-19 positive residents only. Per the assessment, the COVID-19 residents will be housed in a separate wing with dedicated staff, so that staff are not intermingling, and non-positive staff will work with non-positive residents to the extent possible. -During the survey, an interview was conducted with direct care staff (staff #9). Staff #9 stated that symptoms consistent with COVID-19 began on June...2020. Staff #9 stated that on that day, he/she told the staffing coordinator (staff # 23) and the DON of the new onset of cough and a sore throat, but was still assigned to work on a non COVID unit. Staff #9 said when screened	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 21 that day, he/she answered "yes" to cough and sore throat. Staff #9 said that he/she was screened by housekeeping staff (staff #91) that day. During the interview, the screening log for that day was discussed. The log showed that staff #91 had signed the log for screening staff #9 that day. Further review of the log revealed the answers to cough and sore throat were marked "no." Staff #9 said the housekeeping staff (staff #91) must have checked "no." In an interview with staff #91, she did not recall screening staff #9 on that day. Continued in the interview, staff #9 stated that a few days later when screened for a shift on June...2020, he/she answered "yes" to the screening questions regarding new onset for headache, sore throat and loss of taste and smell. Staff #9 said there were several employees saying they were having new onset of symptoms, but no one was making a big deal about it. Staff #9 said that another staff member told him/her that they were experiencing many sick staff, so they did not want any call offs. Staff #9 stated on this same day, the Administrator reported that his/her test result was positive for COVID-19, and was reassigned to work on the COVID hall. Review of the screening log for that day revealed "yes" for headache and sore throat, and for taste and smell a "yes" and a "no" was marked. -During the survey, an interview was conducted with direct care staff (staff #73). Staff #73 said that he/she was symptomatic (today) but was working, as they had no staff. Staff #73 said	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 22 he/she was originally assigned to a non COVID hall that day, but was moved to a COVID hall. Review of the screening log for that day revealed that staff #73 answered "yes" to shortness of breath and "yes" to have you had any contact outside of the facility with someone suspected of having or diagnosed with COVID-19. A follow up interview was conducted with staff #73. Staff #73 said that he/she was sent home today due to answering "yes" to symptoms at screening. Staff #73 said that he/she was experiencing shortness of breath, a headache and muscle aches and that these are the same symptoms that he/she has had for the last month. The screening log for staff #73 today revealed "yes" answers for shortness of breath, muscle pain, headache and "yes" to have you had any contact outside of the facility with someone suspected of having or diagnosed with COVID-19. Also on the log was a section to document "yes" or "no" for Recommend Advance Screening (DON/ICP/designee). If answered "yes" to shortness of breath or cough or to any two of the remaining symptoms. This section was marked "yes." Staff #73 further stated that a few days ago, he/she had a test done which was negative. Staff #73 said that his/her temperature that day was 101.5 degrees F and had a headache and shortness of breath. According to the punch detail, staff #73 did not work that day. However, the screening log for the following day	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 23 revealed that staff #73 answered "yes" to the symptoms of shortness of breath, cough and headache. Per the punch detail report, staff #73 worked that day. The screening log for the next day on June...2020 revealed that staff #73 answered "yes" to shortness of breath, headache and having had contact with someone outside of the facility with suspected of having or diagnosed with COVID-19. The punch detail report included that staff #73 worked a full shift that day. -An interview with direct care staff (staff #70) was conducted during the survey. Staff #70 stated that on June...2020, he/she reported not feeling well and was experiencing symptoms of COVID-19. Staff #70 said that he/she was advised to quarantine for 14 days. Staff #70 said a few days later on June...2020, staff #23 said he/she was able to work with symptoms. Review of the screening log for that day revealed that staff #70 replied "yes" to the symptoms of shortness of breath and cough and had a temperature of 100.9 degrees F. The punch detail report included that staff #73 worked a full shift that day. In the interview, staff #70 further stated that a few days later while working, he/she reported to the DON that he/she was very sick. Staff #70 stated that the DON said he would work on it.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 24 Review of the screening log for that day revealed that staff #70 answered "yes" to shortness of breath, cough and headache. Staff #70 also said at the end of the shift that same day, the DON said he/she had tested positive for COVID-19, but still needed her to work the following day. Per the punch detail report, staff #70 worked a full shift the following day. Regarding the facility screening logs: Upon reviewing the staff screening logs for the month of June 2020, there were multiple entries with "yes" marked by one or more of the symptoms related to COVID-19 as follows: Shortness of breath: approximately 74 yes answers Cough: approximately 162 yes answers New loss of taste or smell: 4 yes answers Repeated shaking with chills: 1 yes answer Muscle pain: approximately 77 yes answers Headache: approximately 99 yes answers Sore throat: approximately 68 yes answers Chills: 11 yes answers G.I. symptoms (diarrhea, vomiting, nausea): approximately 30 yes answers The screening logs further included the following: Regarding having had contact with someone outside the facility with suspected or diagnosed COVID-19 there were 14 yes answers. Regarding having traveled on a cruise or internationally in the last 14 days there were 4 yes answers.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 25 Regarding advance screening by the DON, IP or designee if yes to shortness of breath, cough or any two of the remaining symptoms there were 34 yes answers. The screening logs did not include any follow up that was done for staff who reported having symptoms. An interview was conducted with the staffing coordinator (staff #23) on June 30, 2020 at 2:20 p.m. Staff #23 stated that she does all of the staffing for the nurses and CNAs. Staff #23 said that staff have been getting sicker over the last few days and they have asked some of the staff to pick up extra shifts or stay longer to put in extra hours to help with coverage. She stated they have started to use registry as well, especially for nursing coverage. She said the regular use of registry staff started about a week ago, but registry staff have been in the building on a limited basis for a couple of months. Staff #23 said that things have really fallen apart in the last couple of days. Staff #23 said that staff who have signs or symptoms are sent home. She said if a staff member has a temperature of 100.4 or two of the other signs or symptoms on the screening sheet, they are to be sent home. She said if a staff member answers "yes" to any of the symptoms on the screening sheet, she is to be advised. She said that she will then speak with the staff member and question them to see if the symptoms are new or if they are normal or "baseline" for that staff member. She said that she will also ask them if they have been sick. She stated that if she is not available, the DON, the Infection Preventionist (staff #72), the Administrator or the Assistant Director of Nursing (staff #33) should be contacted by the staff	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 26	F 880		

member or the screener. She said the staff member will be directed as to their eligibility to remain on site or be sent home.

Staff #23 also stated that if a staff member calls out sick, they are to contact her and explain what signs or symptoms they are experiencing. She said if the symptoms are of new onset, she will contact the DON and they will discuss the situation and direct the staff member as to their eligibility to work. She stated that if she cannot be reached, the DON may be contacted directly by the staff member. Staff #23 stated she does not tell anyone that they "have to work." She said that while staff are out sick, they are required to call in twice daily to report symptoms and answer screening questions.

Staff #23 further stated that upon arrival to the building, staff members screen one another before their shift. She said they ask the oncoming staff member if they have any new symptoms, check the appropriate boxes, take their temperature and log it on the sheet. She said that both the screener and the individual being screened in, must sign the sheet. She stated that any staff member can screen someone, as there is not one dedicated screener. She stated that a secondary screening will be done for anyone answering yes to 2 or more symptoms or an elevated temperature. Staff #23 stated that she keeps all of the screening sheets.

In a follow up interview with staff #23 on July 2, 2020 at 2:02 p.m., she said her expectation is that a second screening would be done for any staff member checking yes to 2 or more symptoms on the screening sheet or a temperature of 100.0 degrees F or higher. She

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 _____	C 07/02/2020

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 880	Continued From page 27 said that staff may return to work if they have two negative tests 24 hours apart or no fever for 72 hours, without the use of fever reducing medications. She stated that when staff return from sick leave they will be assigned to the COVID-19 unit, unless otherwise specified by the DON. She stated that staff who are asymptomatic but COVID-19 positive, may work on the COVID unit only. She stated that the DON makes the decision if staff can work, but no one is forced to work. Review of the facility's policy titled, Emerging Infectious Disease Emergency Plan Coronavirus (COVID-2019) dated March 2020, revealed under the section for staffing that during an emergency, the Administer or the Director of Nursing may declare the facility is experiencing an emergency due to COVID-19. This includes calling staff from all departments and directing them to either report for duty immediately or be scheduled for future shifts. All staff may be assigned to full, halftime or overtime shifts and may be scheduled to work on their days off. The policy stated that if staff are ill, have a fever, a cough or respiratory compromise or have other symptoms consistent with a contagious process, they should not present to the facility for regular or emergency duty, unless it is in response to a pandemic outbreak involving the facility itself, such as COVID-19. In that case, if the facility has confirmed cases of COVID-19 and staff that have confirmed or suspected COVID-19 with mild-moderate symptoms, will report to duty to work with only COVID positive residents, who are segregated from other residents and staff. A separate entrance will be made and separate time logs will be kept for those staff members.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 28 Review of the CDC guidance titled, Preparing for COVID-19 in Nursing Homes updated June 25, 2020, revealed the facility should screen all healthcare personnel (HCP) at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. The facility should remind HCP to stay home when they are ill. If HCP develops a fever (temperature of 100.0 degrees F) or other symptoms consistent with COVID-19 while at work, they should inform their supervisor and leave the workplace. If they are ill, staff should keep their cloth face covering or facemask on and leave the workplace. The guidance stated that a fever is either a measured temperature greater than 100.0 degrees F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications such as fever reducing medications. HCP with suspected COVID-19 should be prioritized for testing. The CDC guidelines further included to implement sick leave policies that are non-punitive, flexible and consistent with public health policies that support HCP to stay home when ill. The guidelines stated to reinforce sick leave policies and remind HCP not to report to work when ill. In addition, the guidelines stated that facilities should have a plan in place regarding how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers). The guidance also included to develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.	F 880		

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 _____	C 07/02/2020

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 880	Continued From page 29 Review of the CDC guidance regarding Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 dated May 5, 2020 revealed the following: Symptomatic HCP with suspected or confirmed COVID-19 should be excluded from work for at least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of medication to reduce fever and improvement in respiratory symptoms (e.g., cough, shortness of breath); and at least 10 days have passed since symptoms first appeared. The guidance stated that if using a test based strategy, fever must resolve without the use of fever reducing medication, respiratory symptoms such as cough and shortness of breath must improve and 2 negative test results at least 24 hours apart must be documented. Under the section for Strategies to Mitigate HCP Staffing Shortages, it stated that staffing shortages will likely occur due to HCP exposures, illness or need to care for family members at home. Facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them.	F 880		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

September 17, 2020

Important Notice - Please Read Carefully

Sean Hill, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Re: Complaint Intake #AZ00165550 & AZ00165552
Investigation # 9VH211

Dear Mr. Hill:

Surveyors of the Arizona Department of Health Services (Department) 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 at least one of the allegations was found to be substantiated.

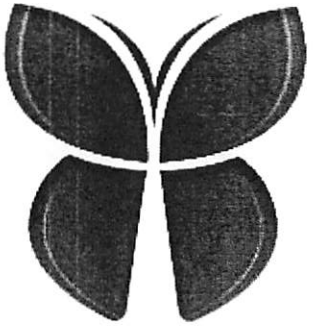
You are in receipt of a Statement of Deficiencies that reflect the finding of this survey.

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

Sincerely,

Sandy Farmer
LTC Customer Service Representative IV
Bureau of Long Term Care Licensing

Supplemental



IPCWELL

GRANITE CREEK
INFECTION PREVENTION AND CONTROL TARGETED IN SERVICE
DR. BUFFY LLOYD-KREJCI, DRPH, M.S., CIC

PLAN OF CORRECTION

F880 -- §483.80 Infection Control

The facility failed to maintain an effective infection control program which included corrective measures to minimize or prevent the spread of infections, by having multiple staff who were either symptomatic and positive for COVID-19 or exhibited symptoms of COVID-19 and provided care to residents.

FEDERAL REGULATIONS

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

483.80 Infection Control

The facility must establish and maintain ***an infection prevention and control program*** *designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections*

FEDERAL REGULATIONS

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

483.80(a) Infection Prevention and Control Program

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum….

483.80(a)(1) *A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards*

FEDERAL REGULATIONS

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

- 483.80(a)(2) *Written standards, policies, and procedures for the program, which must include, but are not limited to:*
  - Surveillance designed to identify possible communicable diseases or infections before they can spread
  - When and whom possible incidents of communicable disease or infections should be reported
  - Standard and transmission-based precautions to be followed to prevent spread of infections
  - When and how isolation should be used for a resident; including but not limited to:
    - The type and duration of the isolation
    - A requirement that the isolation should be the least restrictive possible
  - The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food
  - The hand hygiene procedures to be followed by staff involved in direct resident contact

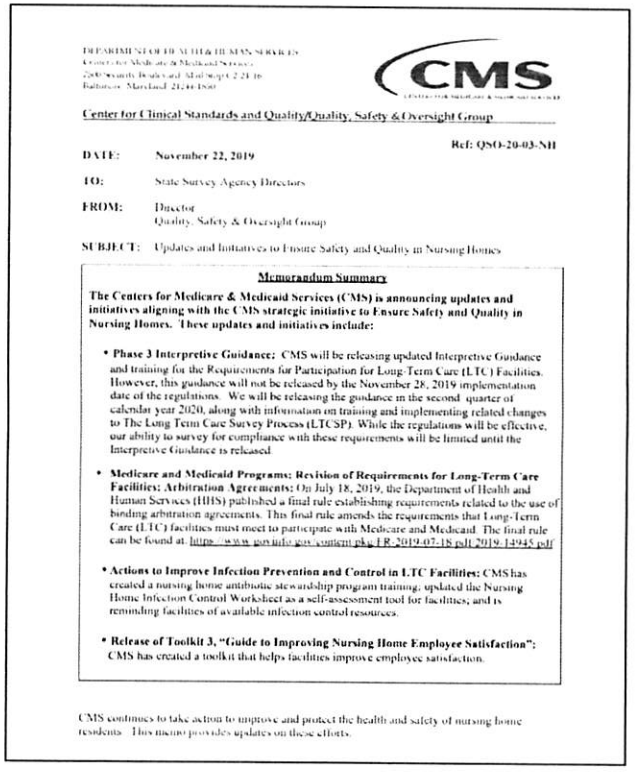
FEDERAL REGULATIONS

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

- 483.80(a)(4) *A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility*
- *483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary*

IPC FACILITY-WIDE ASSESSMENT

- CMS Facility –Wide Assessment Tool: https://www.cms.gov/files/document/qso-20-03-nh
- CDC ICAR: https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-03-NH

DATE: November 22, 2019

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

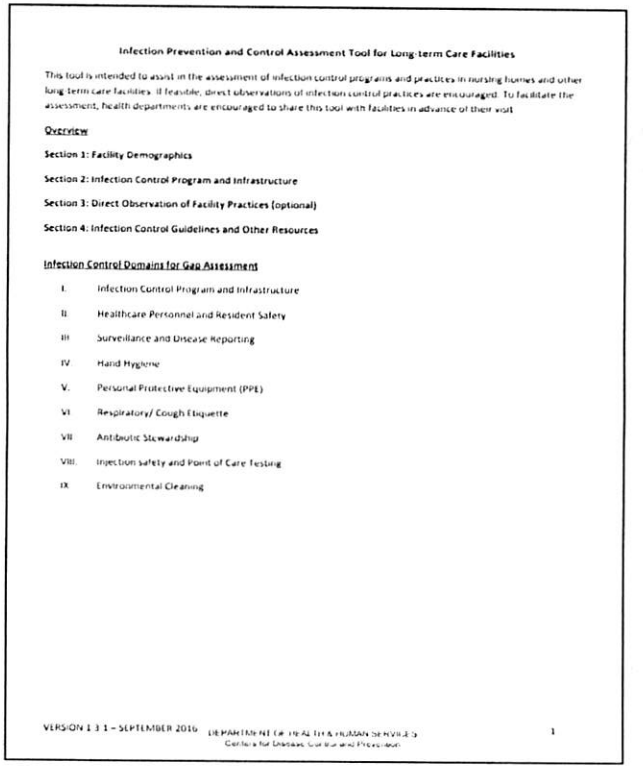
SUBJECT: Updates and Initiatives to Ensure Safety and Quality in Nursing Homes

Memorandum Summary

The Centers for Medicare & Medicaid Services (CMS) is announcing updates and initiatives aligning with the CMS strategic initiative to Ensure Safety and Quality in Nursing Homes. These updates and initiatives include:

- **Phase 3 Interpretive Guidance:** CMS will be releasing updated Interpretive Guidance and training for the Requirements for Participation for Long-Term Care (LTC) Facilities. However, this guidance will not be released by the November 28, 2019 implementation date of the regulations. We will be releasing the guidance in the second quarter of calendar year 2020, along with information on training and implementing related changes to The Long Term Care Survey Process (LTCSP). While the regulations will be effective, our ability to survey for compliance with these requirements will be limited until the Interpretive Guidance is released.
- **Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities; Arbitration Agreements:** On July 18, 2019, the Department of Health and Human Services (HHS) published a final rule establishing requirements related to the use of binding arbitration agreements. This final rule amends the requirements that Long-Term Care (LTC) facilities must meet to participate with Medicare and Medicaid. The final rule can be found at: https://www.govinfo.gov/content/pkg/FR-2019-07-18/pdf/2019-14945.pdf
- **Actions to Improve Infection Prevention and Control in LTC Facilities:** CMS has created a nursing home antibiotic stewardship program training; updated the Nursing Home Infection Control Worksheet as a self-assessment tool for facilities; and is reminding facilities of available infection control resources.
- **Release of Toolkit 3, "Guide to Improving Nursing Home Employee Satisfaction":** CMS has created a toolkit that helps facilities improve employee satisfaction.

CMS continues to take action to improve and protect the health and safety of nursing home residents. This memo provides updates on these efforts.



Infection Prevention and Control Assessment Tool for Long-term Care Facilities

This tool is intended to assist in the assessment of infection control programs and practices in nursing homes and other long-term care facilities. If feasible, direct observations of infection control practices are encouraged. To facilitate the assessment, health departments are encouraged to share this tool with facilities in advance of their visit.

Overview

Section 1: Facility Demographics

Section 2: Infection Control Program and Infrastructure

Section 3: Direct Observation of Facility Practices (optional)

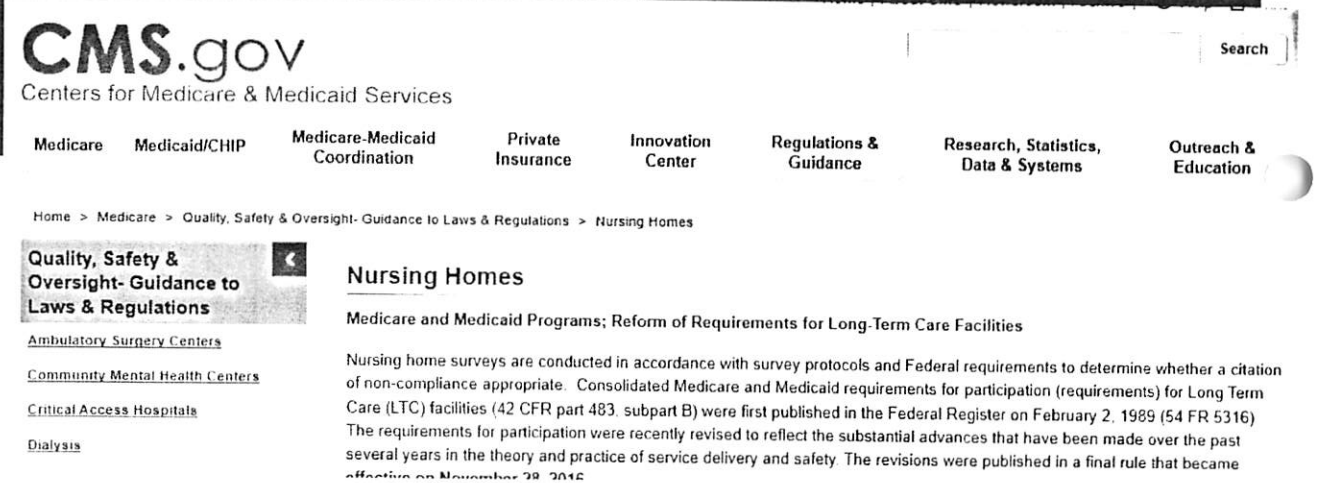
Section 4: Infection Control Guidelines and Other Resources

Infection Control Domains for Gap Assessment

I. Infection Control Program and Infrastructure
II. Healthcare Personnel and Resident Safety
III. Surveillance and Disease Reporting
IV. Hand Hygiene
V. Personal Protective Equipment (PPE)
VI. Respiratory/ Cough Etiquette
VII. Antibiotic Stewardship
VIII. Injection Safety and Point of Care Testing
IX. Environmental Cleaning

CMS SURVEY RESOURCES

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes



In Google Search:
"Long term Care Survey Resources"

F-Tag Crosswalk (XLSX)

LTCSP Interim Revisit Instructions - Updated 08/03/2018 (PDF)

Survey Resources – UPDATED 05/15/2020 (ZIP)

New Long-term Care Survey Process – Slide Deck and Speaker Notes (PPTX)

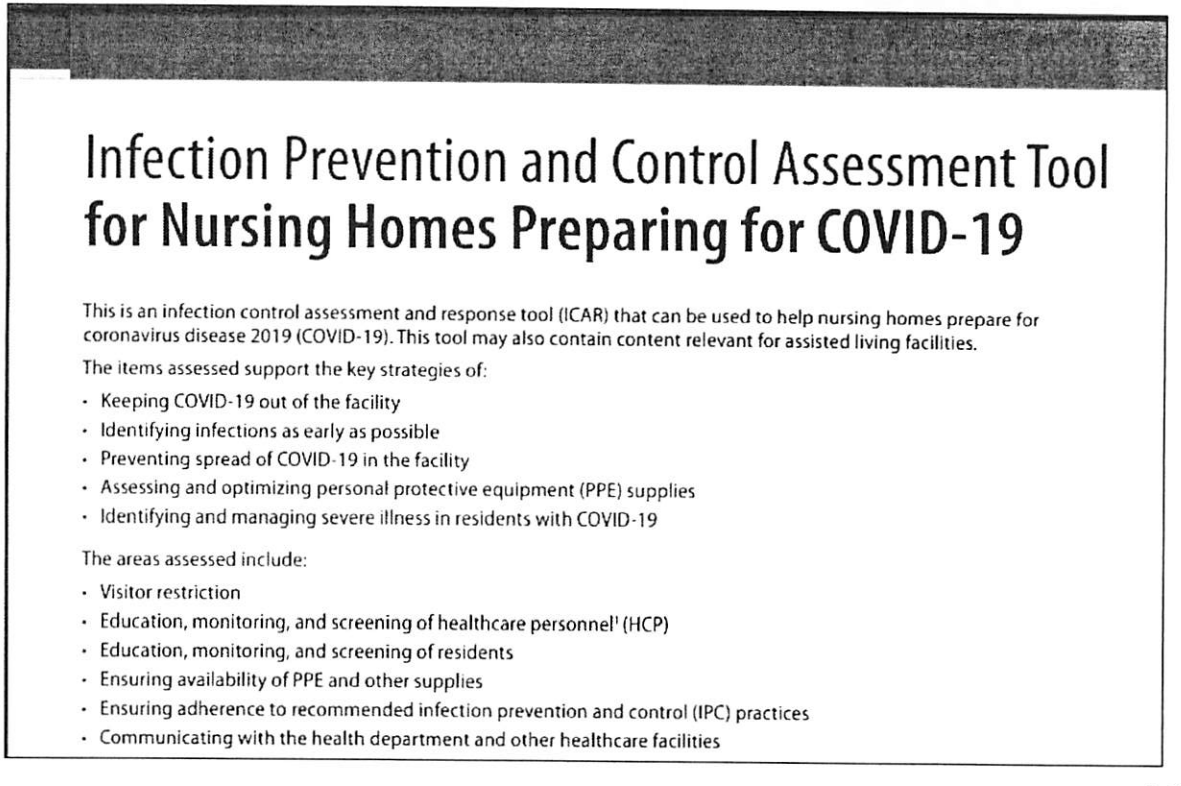
Appendix PP State Operations Manual (Revised 11/22/2017) (PDF)

Revision History for LTC Survey Process Documents and Files UPDATED 05/15/2020 (PDF)

IPC FACILITY-WIDE ASSESSMENT COVID-19

https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf

In Google Search:
"Long term Care COVID ICAR"



Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

This is an infection control assessment and response tool (ICAR) that can be used to help nursing homes prepare for coronavirus disease 2019 (COVID-19). This tool may also contain content relevant for assisted living facilities.

The items assessed support the key strategies of:

- Keeping COVID-19 out of the facility
- Identifying infections as early as possible
- Preventing spread of COVID-19 in the facility
- Assessing and optimizing personal protective equipment (PPE) supplies
- Identifying and managing severe illness in residents with COVID-19

The areas assessed include:

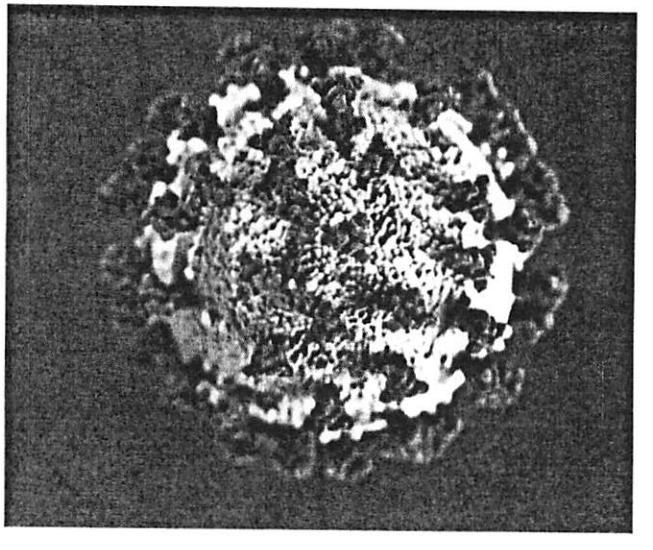
- Visitor restriction
- Education, monitoring, and screening of healthcare personnel[1] (HCP)
- Education, monitoring, and screening of residents
- Ensuring availability of PPE and other supplies
- Ensuring adherence to recommended infection prevention and control (IPC) practices
- Communicating with the health department and other healthcare facilities

COVID-19

CORONAVIRUS (COVID-19)

COVID-19 is a respiratory disease that can spread from person to person

The virus that causes COVID-19 is Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)



https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it

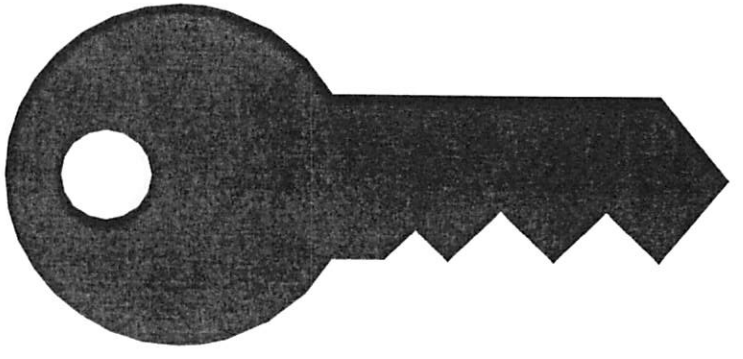
CDC STRATEGIES TO PREVENT THE SPREAD OF COVID-19 IN LONG-TERM CARE FACILITIES

- Post signs at the entrance instructing visitors not to visit if they have symptoms of respiratory infection
- Ensure sick leave policies allow employees to stay home if they have symptoms of respiratory infection
- Monitor residents and employees for fever or respiratory symptoms
- Support hand and respiratory hygiene, as well as cough etiquette by residents, visitors, and employees
- Identify dedicated employees to care for COVID-19 patients and provide infection control training
- Provide the right supplies to ensure easy and correct use of PPE

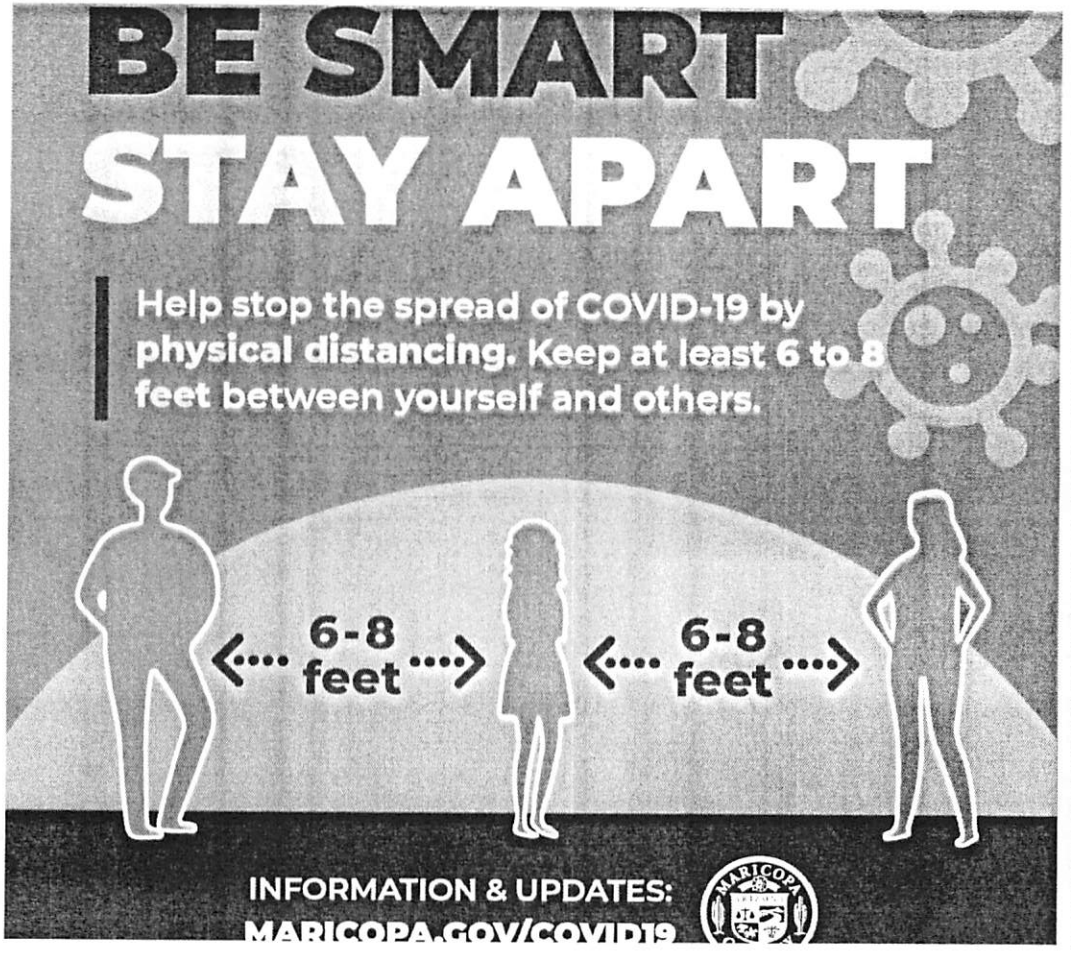
https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.htm

KEY PREVENTION STRATEGIES

- Wash your hands often
- Cover your mouth and nose with a cloth face cover when around others
- Cover coughs and sneezes
- Clean and disinfect



https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html



KEY PREVENTION STRATEGIES

FOR ALL EMPLOYEES, VOLUNTEERS, & VISITORS

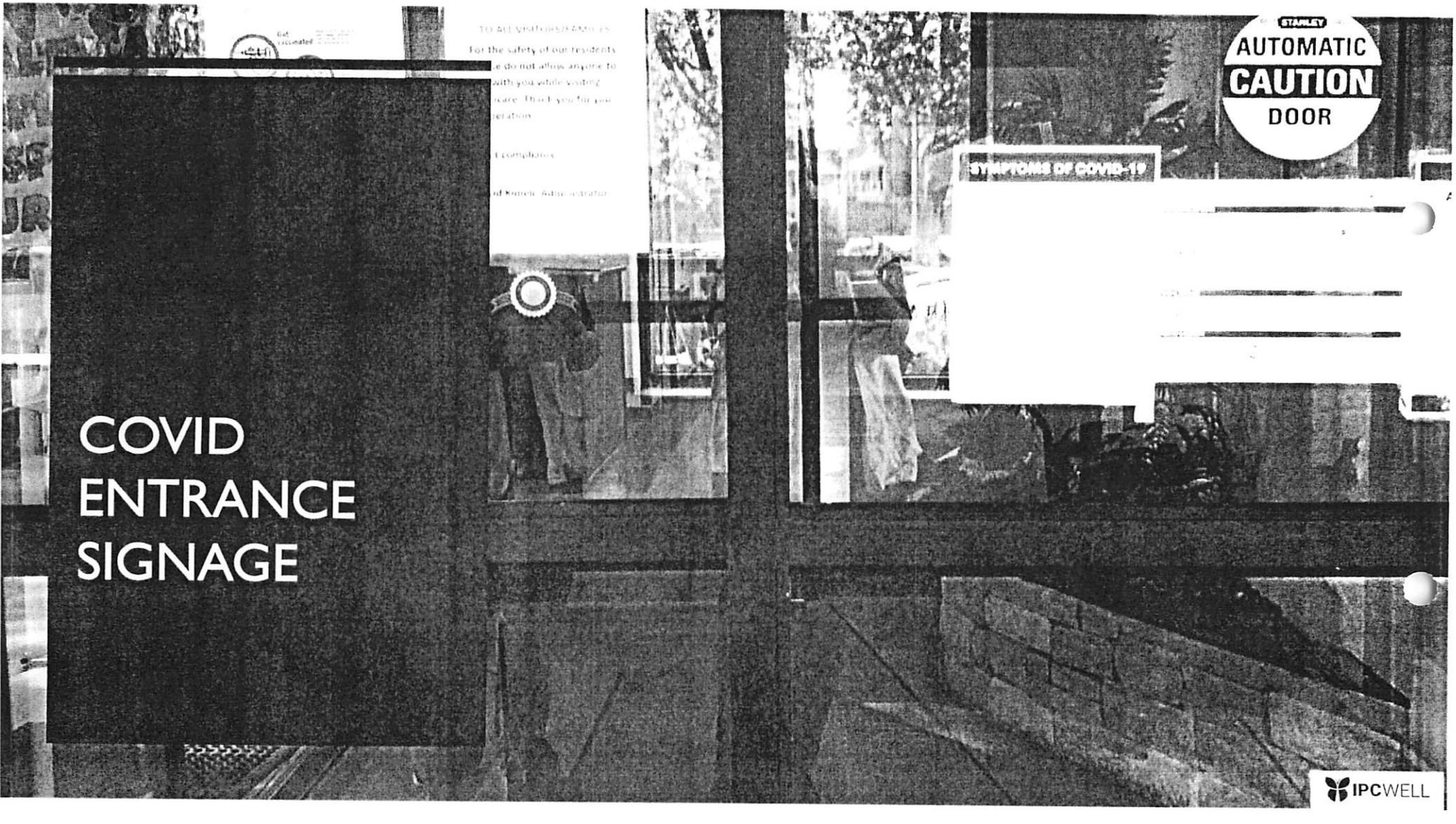
DO NOT COME INTO ANY WORK LOCATION IF YOU ARE EXPERIENCING:

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell

PLEASE NOTIFY YOUR SUPERVISOR AND SEE IF ARRANGEMENTS CAN BE MADE TO WORK REMOTELY.

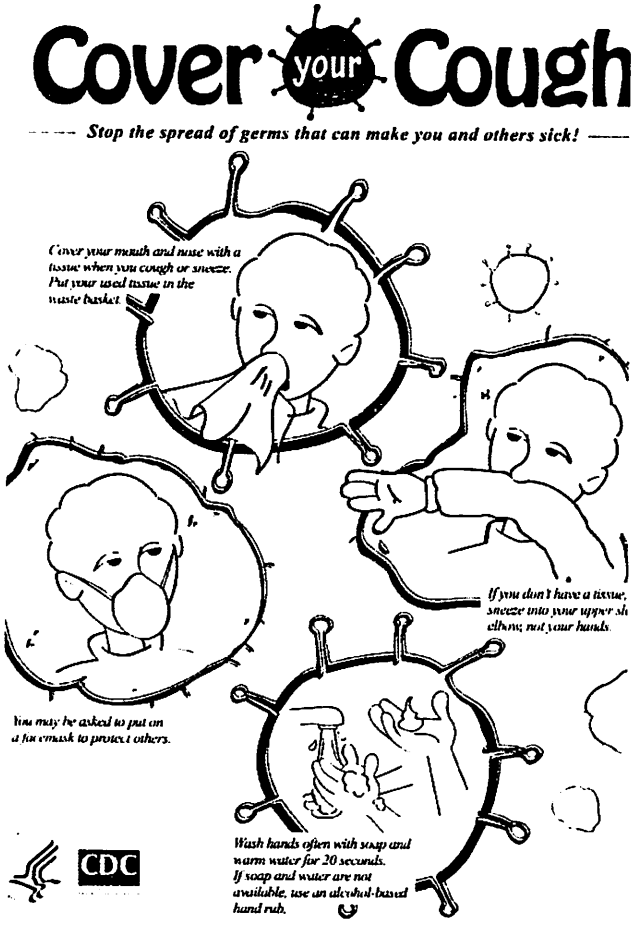
KEY PREVENTION STRATEGIES

IPCWELL



COVID ENTRANCE SIGNAGE

RESPIRATORY HYGIENE/ COUGH ETIQUETTE



- Respiratory hygiene & cough etiquette prevent residents, HCWs, and family and friends with respiratory infections from transmitting their infection to others

- Measures such as hand washing, and proper PPE should be incorporated into infection prevention practices as one component of Standard Precautions

https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm

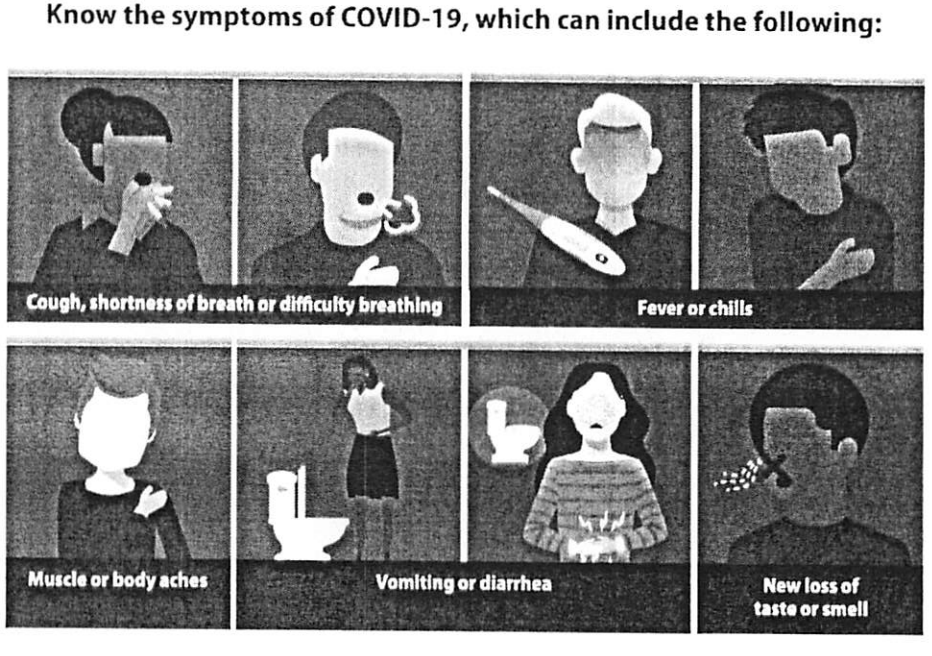
https://www.cdc.gov/flu/pdf/protect/cdc_cough.pdf

COVID SIGNS AND SYMPTOMS

It takes between 2–14 days after exposure for symptoms of COVID-19 to develop (median is ~4 days).

Common symptoms include

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea



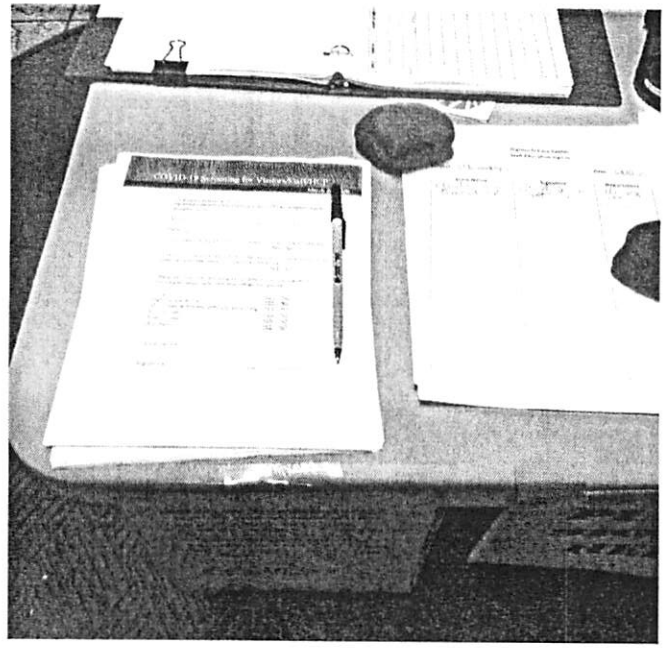
https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms-24x36-en.pdf

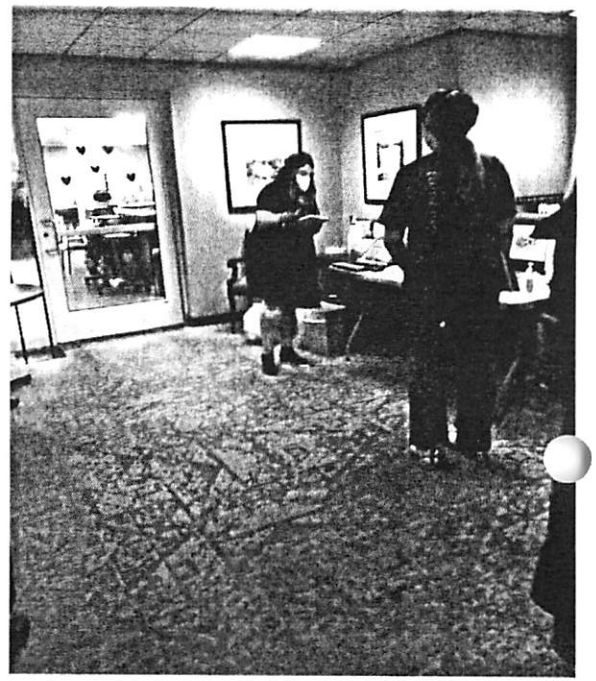
IPCWELL

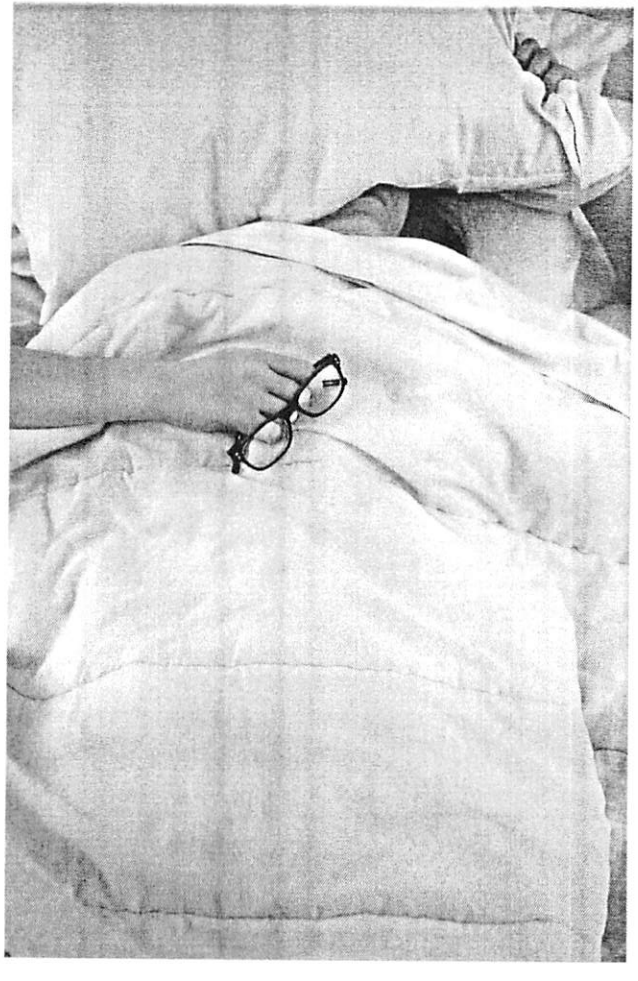
POPULATION AT RISK

- People in communities with ongoing community spread
- Elderly
- Immunocompromised
- Healthcare workers caring for patients with COVID-19
- Close contacts of persons with COVID-19

COVID SCREENING

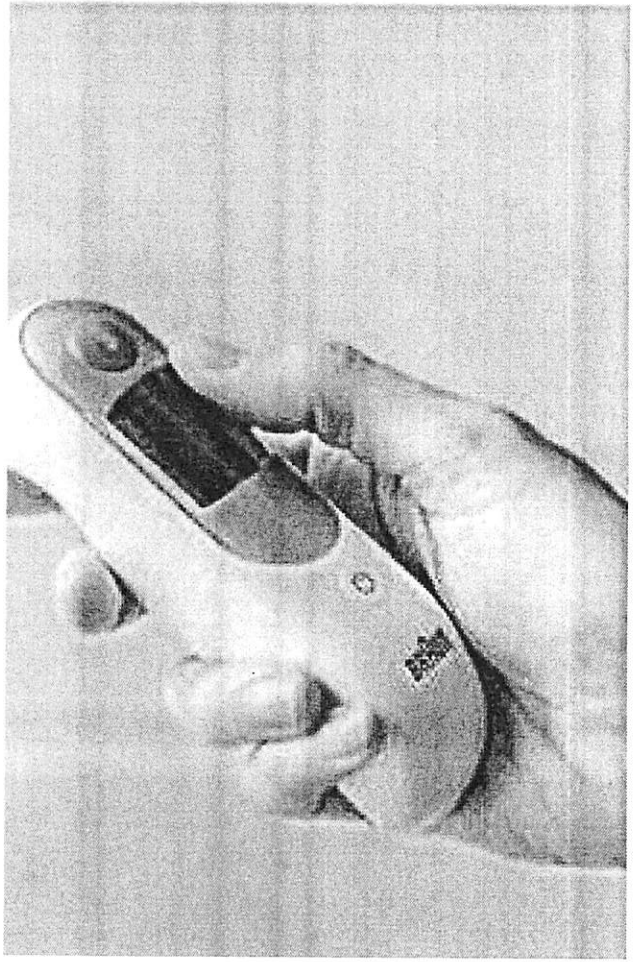






EVALUATE AND MANAGE HEALTHCARE PERSONNEL

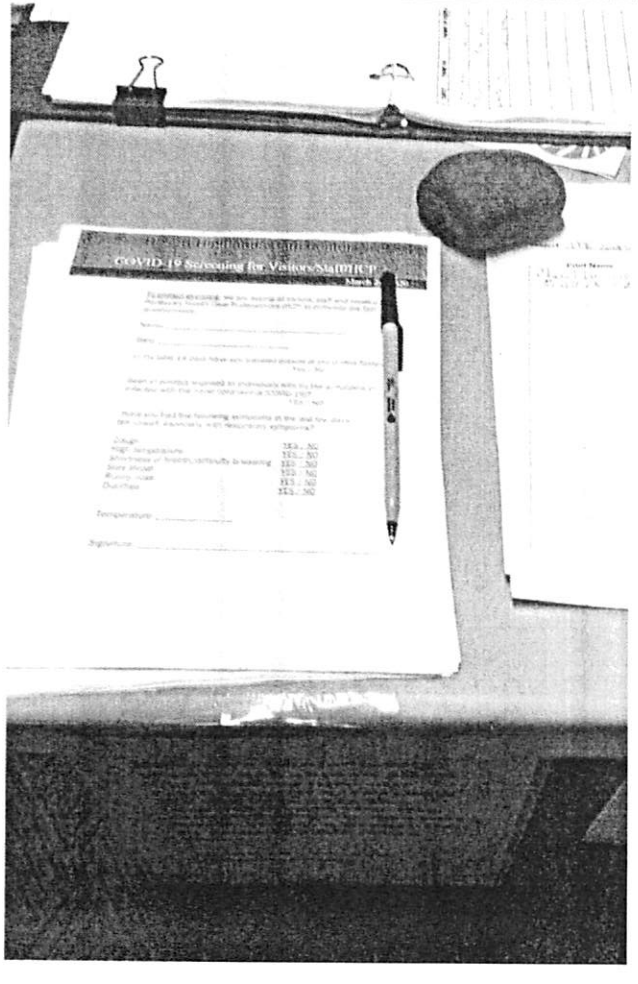
- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Create an inventory of all volunteers and personnel who provide care in the facility.
- Use that inventory to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.



EVALUATE AND MANAGE HEALTHCARE PERSONNEL

- As part of routine practice, ask **HCP to regularly monitor themselves** for fever and symptoms consistent with COVID-19.
  - Remind HCP to stay home when they are ill.
  - If HCP develop fever (T≥100.0°F) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace.
  - Have a plan for how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers).

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html



EVALUATE AND MANAGE HEALTHCARE PERSONNEL

Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19.

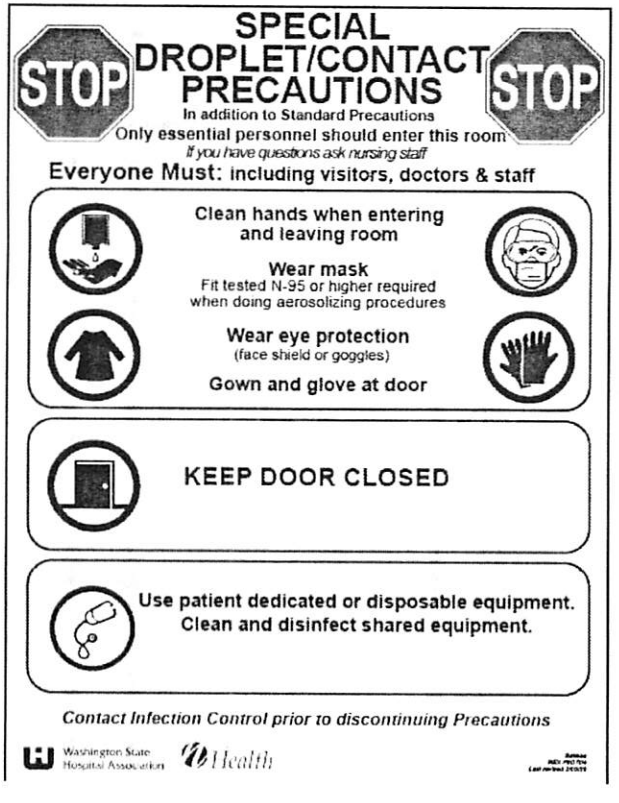
- **Actively take their temperature*** and document absence of symptoms consistent with COVID-19.
- If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
- *Fever is either measured temperature >100.0°F or subjective fever.
- HCP who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.

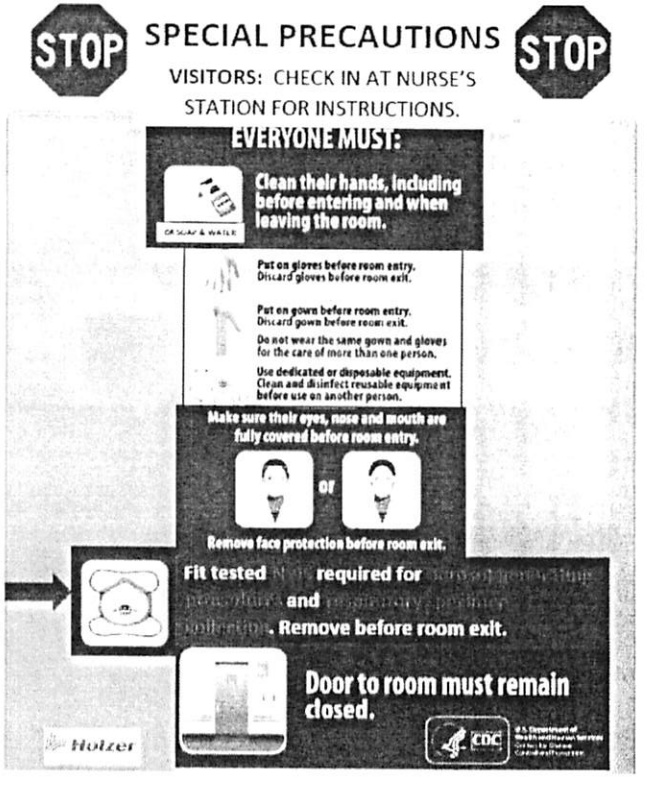
EVALUATE AND MANAGE HEALTHCARE PERSONNEL

- Develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.
- CDC has created guidance to assist facilities with mitigating staffing shortages.
- For guidance on when HCP with suspected or confirmed COVID-19 may return to work.

Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Flong-term-care-strategies.html (Interim Guidance)

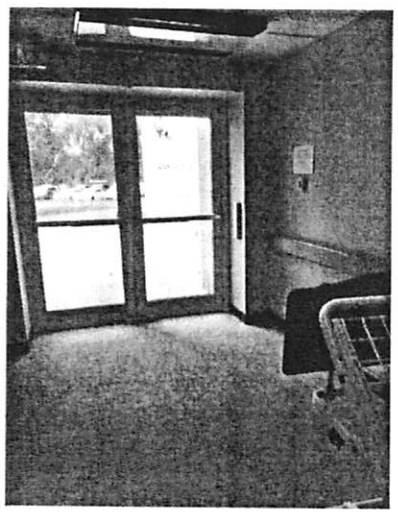
COVID SIGNAGE

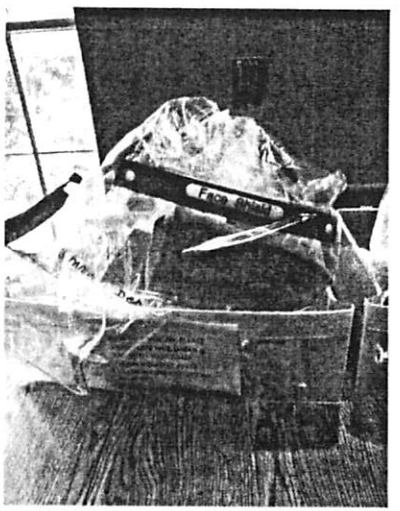


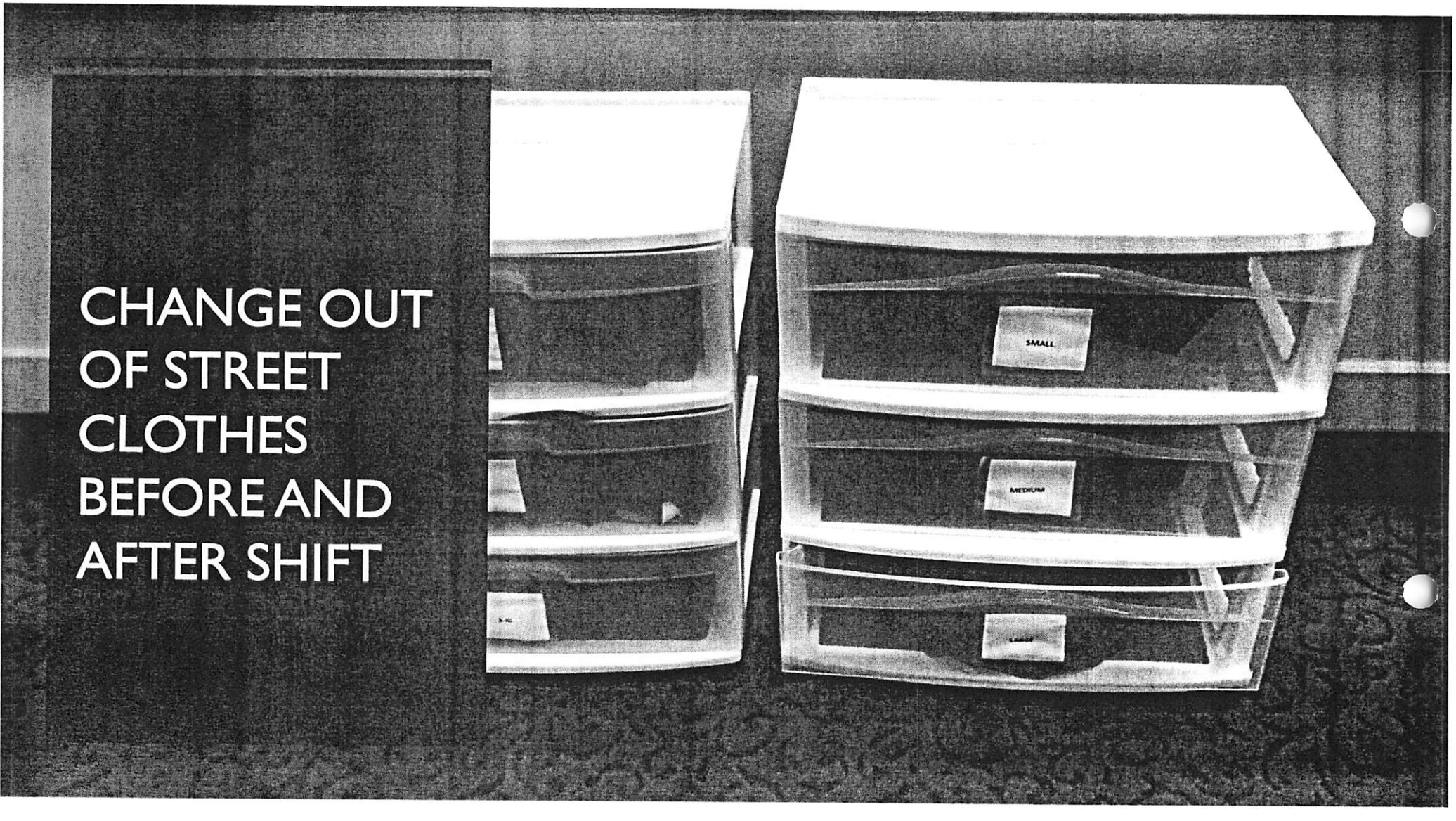


COVID COHORTING

- COVID Positive
- PUI (patients under investigation)
- Admissions/Readmissions/Medical Appointments
- Residents refusing testing




CHANGE OUT
OF STREET
CLOTHES
BEFORE AND
AFTER SHIFT
SMALL
MEDIUM

DISCONTINUATION OF ISOLATION: JULY 22, 2020 UPDATE

- Available data indicate that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset.

- Persons with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset.

- Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset, albeit at concentrations considerably lower than during illness, in ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely.

- Evidence recommends relying on a symptom based, rather than test-based strategy for ending isolation of these patients, so that persons who are by current evidence no longer infectious are not kept unnecessarily isolated and excluded from work or other responsibilities.

://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

RELEASE FROM ISOLATION GUIDANCE

ARIZONA DEPARTMENT
OF HEALTH SERVICES

'Release from Isolation' Guidance

Recommendations for discontinuation of transmission-based precautions and home isolation, based upon a person's symptoms and clinical testing are below. The most recent updates to this document can be found here.

- If a person is **symptomatic*** and awaiting COVID-19 test results:
  - Stay home away from others or under isolation precautions until results are available. If results are delayed, follow guidance for symptomatic and tested positive for COVD-19. Once results are available, follow the recommendations below based on results.
- If a person is **symptomatic*** and tested positive for COVID-19 by PCR, antigen testing, or serology**:
  - Stay home away from others or under isolation precautions until you have had no fever for at least 3 days (72 hours) without the use of medicine that reduces fevers; AND
  - Other symptoms have improved; AND
  - At least 10 days have passed since symptoms first appeared.
- If a person is **symptomatic*** and tested negative for COVID-19 by PCR, antigen testing, or serology**:
  - Stay home away from others or under isolation precautions until you have had no fever for at least 3 days (72 hours) without the use of medicine that reduces fevers; AND
  - Other symptoms have improved

https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/public-resources/release-from-isolation.pdf

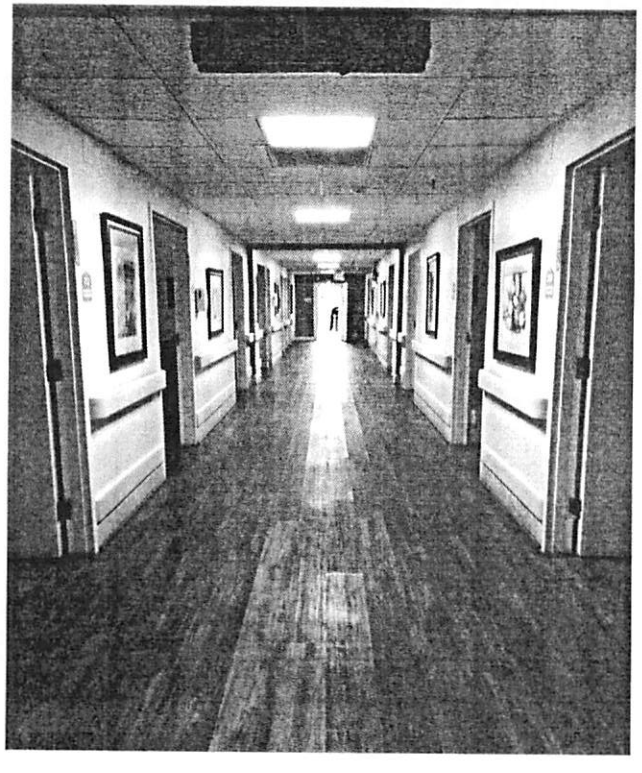
ARIZONA DEPARTMENT
OF HEALTH SERVICES

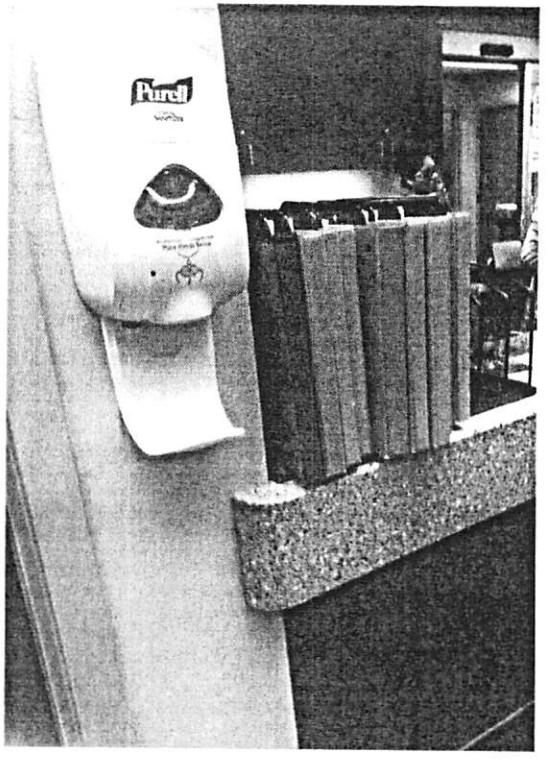
Recent Updates to Guidance

Changes were made to add antigen testing, serial testing of asymptomatic individuals, and updates to serologic testing of asymptomatic individuals:

- If a person is asymptomatic and tested positive for COVID-19 by PCR or antigen testing (even if person met time and symptom-based strategy for release from isolation after being symptomatic and tested positive for COVD-19):
  - Stay home away from others or under isolation precautions until 10 days have passed since specimen collection of the first positive COVID-19 PCR/antigen testing while asymptomatic.
  - If symptoms develop, follow guidance for symptomatic and tested positive for COVD-19.
- If a person is asymptomatic and tested positive for COVID-19 by serology:
  - No isolation is required since there is a low likelihood of active infection.
  - Take everyday precautions to prevent the spread of COVID-19.

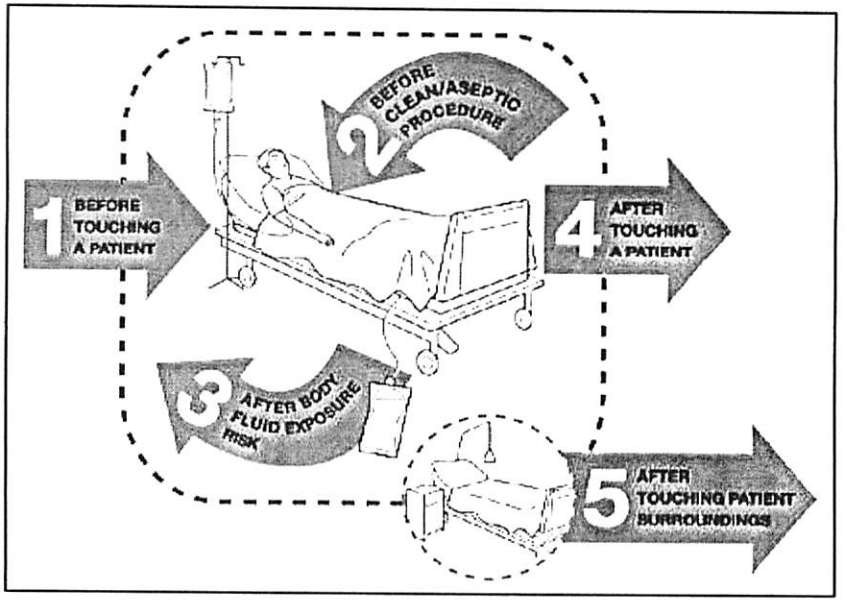
HAND HYGIENE





HAND HYGIENE MOMENTS

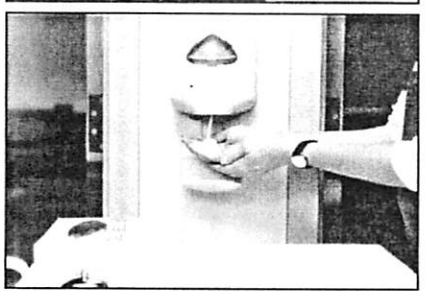
- Must be performed even if gloves are used
- Before and after contact with the resident
- Before performing an aseptic task
- After contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident room
- After removing personal protective equipment (e.g., gloves, gown, facemask).
- After using the restroom
- Before meals

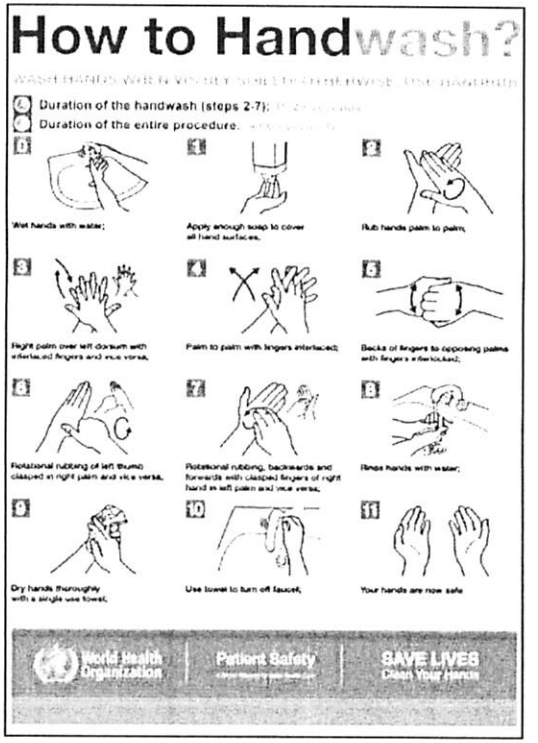


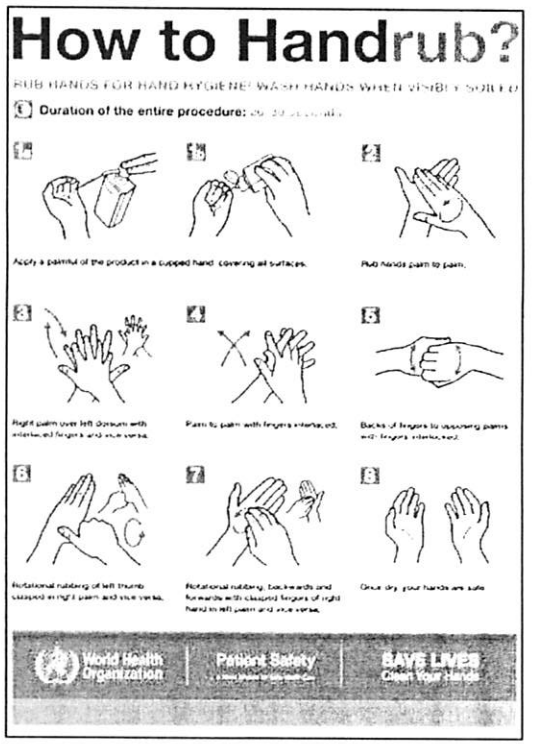
https://www.who.int/infection-prevention/campaigns/clean-hands/5moments/en/

HAND WASHING VS. HAND SANITIZER

- Hand sanitizer is the preferred method for washing hands in most situations
- Consider having hand sanitizer in the resident room **and** in the halls



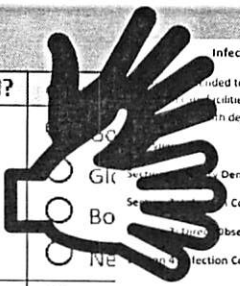




HAND HYGIENE AUDIT TOOL

Hand Hygiene and Contact Precautions Observations

Staff type*	Type of opportunity	HH performed?	Gown or glove indicated?	
Click here to enter text.	○ Room entry ○ Room exit ○ Before resident contact ○ After resident contact ○ Before glove ○ After glove ○ Other: Click here to enter text.	○ Alcohol-rub ○ Hand Wash ○ No HH done	○ Gown only ○ Glove only ○ Both ○ No	○ Bo ○ Ne
Click here to enter text.	○ Room entry ○ Room exit ○ Before resident contact ○ After resident contact ○ Before glove ○ After glove ○ Other: Click here to enter text.	○ Alcohol-rub ○ Hand Wash ○ No HH done	○ Gown only ○ Glove only ○ Both ○ No	○ Go ○ Gl ○ Bo ○ Ne
Click here to enter text.	○ Room entry ○ Room exit ○ Before resident contact ○ After resident contact ○ Before glove ○ After glove ○ Other: Click here to enter text.	○ Alcohol-rub ○ Hand Wash ○ No HH done	○ Gown only ○ Glove only ○ Both ○ No	○ Go ○ Gl ○ Both ○ Neither



Infection Prevention and Control Assessment Tool for Long-term Care Facilities

…nded to assist in the assessment of infection control programs and practices in nursing homes and other …cilities. If feasible, direct observations of infection control practices are encouraged. To facilitate the …h departments are encouraged to share this tool with facilities in advance of their visit.

- … Demographics
- Se… Control Program and Infrastructure
- … Observation of Facility Practices (optional)
- … fection Control Guidelines and Other Resources

Infection Control Domains for Gap Assessment

I.	Infection Control Program and Infrastructure
II.	Healthcare Personnel and Resident Safety
III.	Surveillance and Disease Reporting
IV.	Hand Hygiene
V.	Personal Protective Equipment (PPE)
VI.	Respiratory/ Cough Etiquette
VII.	Antibiotic Stewardship
VIII.	Injection safety and Point of Care Testing

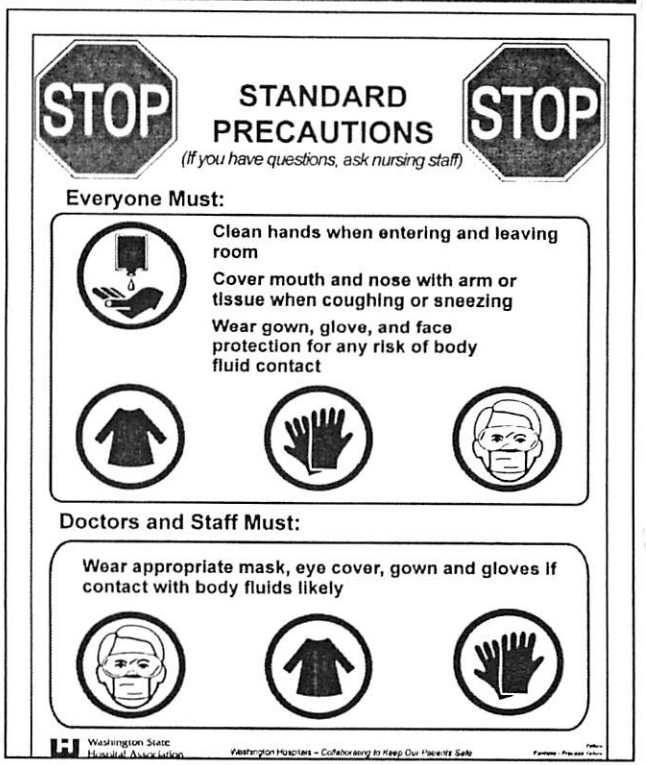
https://www.cdc.gov/infectioncontrol/pdf/icar/ltcf.pdf

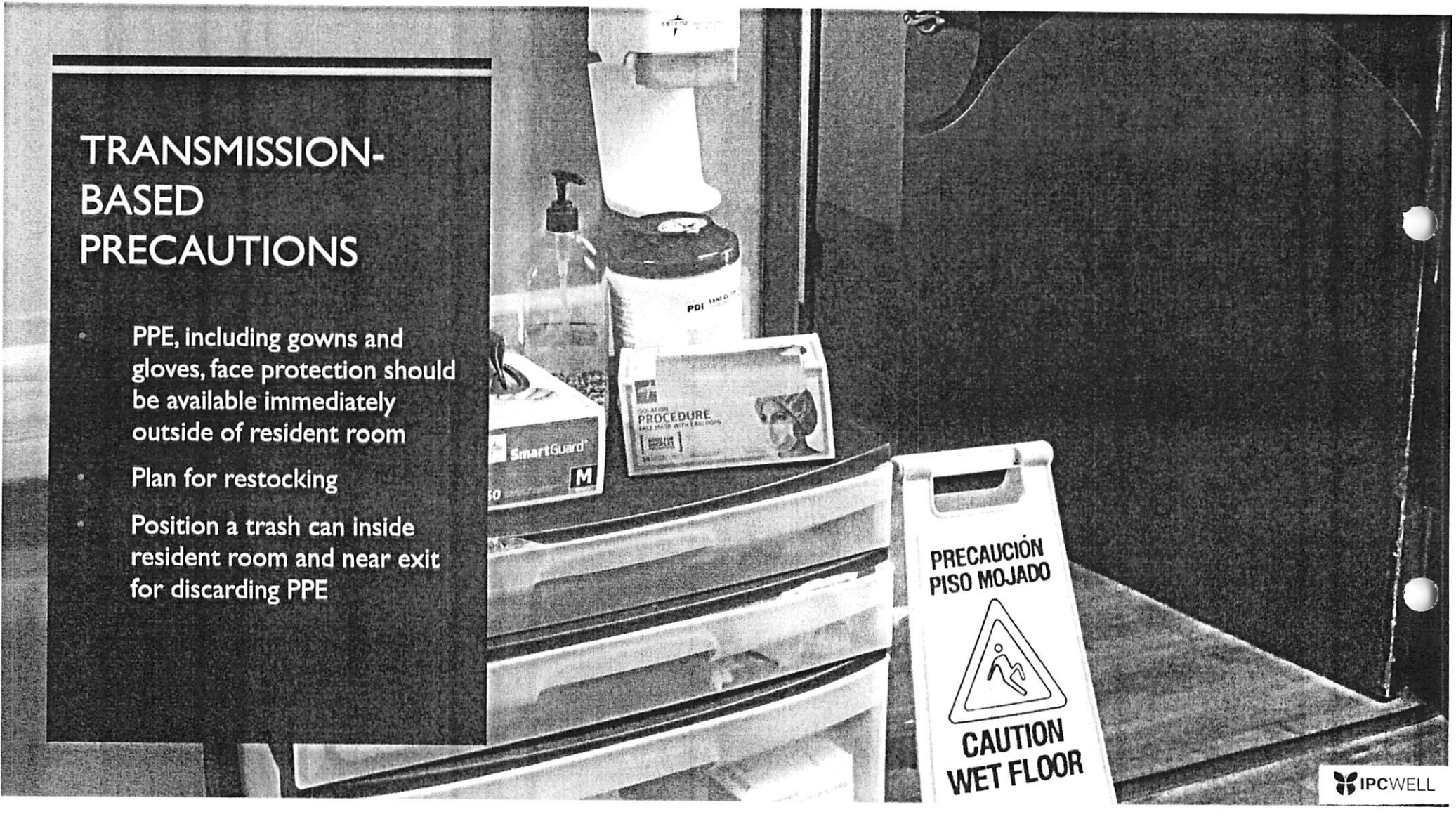
IPCWELL

STANDARD PRECAUTIONS

Standard Precautions are a group of infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status

- Apply to all resident care, regardless of suspected or confirmed infection status of the resident
- Protect healthcare staff and residents by preventing the spread of infections among residents
- Ensure staff do not carry infectious pathogens on their hands or via equipment during resident care

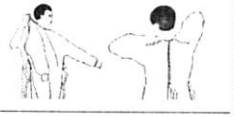



TRANSMISSION-BASED PRECAUTIONS
PPE, including gowns and gloves, face protection should be available immediately outside of resident room
Plan for restocking
Position a trash can inside resident room and near exit for discarding PPE
PDI
PROCEDURE
SmartGuard
M
PRECAUCIÓN
PISO MOJADO
CAUTION
WET FLOOR
IPCWELL

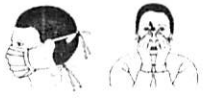
DONNING AND DOFFING

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. GOWN
   - Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
   - Fasten in back of neck and waist



2. MASK OR RESPIRATOR
   - Secure ties or elastic bands at middle of head and neck
   - Fit flexible band to nose bridge
   - Fit snug to face and below chin
   - Fit check respirator



3. GOGGLES OR FACE SHIELD
   - Place over face and eyes and adjust to fit

4. GLOVES
   - Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

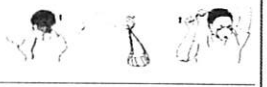
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

1. GLOVES
   - Outside of gloves are contaminated!
   - If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove.
   - Hold removed glove in gloved hand.
   - Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove.
   - Discard gloves in a waste container.

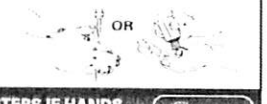
2. GOGGLES OR FACE SHIELD
   - Outside of goggles or face shield are contaminated!
   - If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Remove goggles or face shield from the back by lifting head band or ear pieces.
   - If the item is reusable, place in designated receptacle for later reprocessing. Otherwise, discard in a waste container.

3. GOWN
   - Gown front and sleeves are contaminated!
   - If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Pull gown away from neck and shoulders, touching inside of gown only.
   - Turn gown inside out.
   - Fold or roll into a bundle and discard in a waste container.

4. MASK OR RESPIRATOR
   - Front of mask/respirator is contaminated — DO NOT TOUCH!
   - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front.
   - Discard in a waste container.



5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

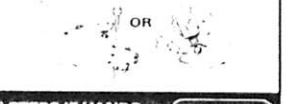
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

1. GOWN AND GLOVES
   - Gown front and sleeves and the outside of gloves are contaminated!
   - If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Grasp the gown in the front and pull away from your body so that the ties break. Turning only outside of gown is contaminated.
   - Avoid touching the gown. Fold or roll the gown inside out into a bundle.
   - As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown as they are being removed. Place the gown and gloves into a waste container.

2. GOGGLES OR FACE SHIELD
   - Outside of goggles or face shield are contaminated!
   - If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Remove goggles or face shield from the back by lifting head band or ear pieces without touching the front of the goggles or face shield.
   - If the item is reusable, place in designated receptacle for later reprocessing. Otherwise, discard in a waste container.

3. MASK OR RESPIRATOR
   - Front of mask/respirator is contaminated — DO NOT TOUCH!
   - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer.
   - Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front.
   - Discard in a waste container.

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



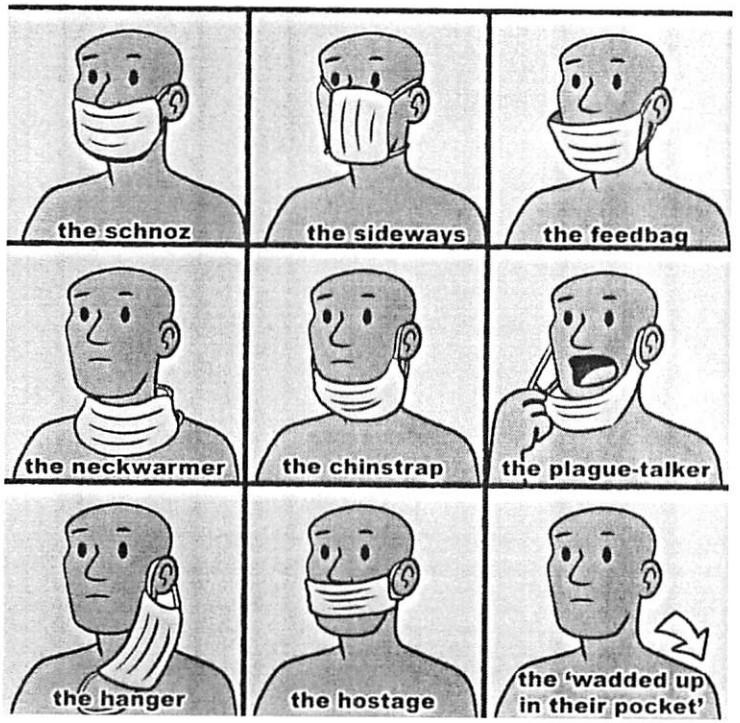
PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

https://www.cdc.gov/hai/prevent/ppe.html

IPCWELL

FACE MASK DO'S AND DON'TS

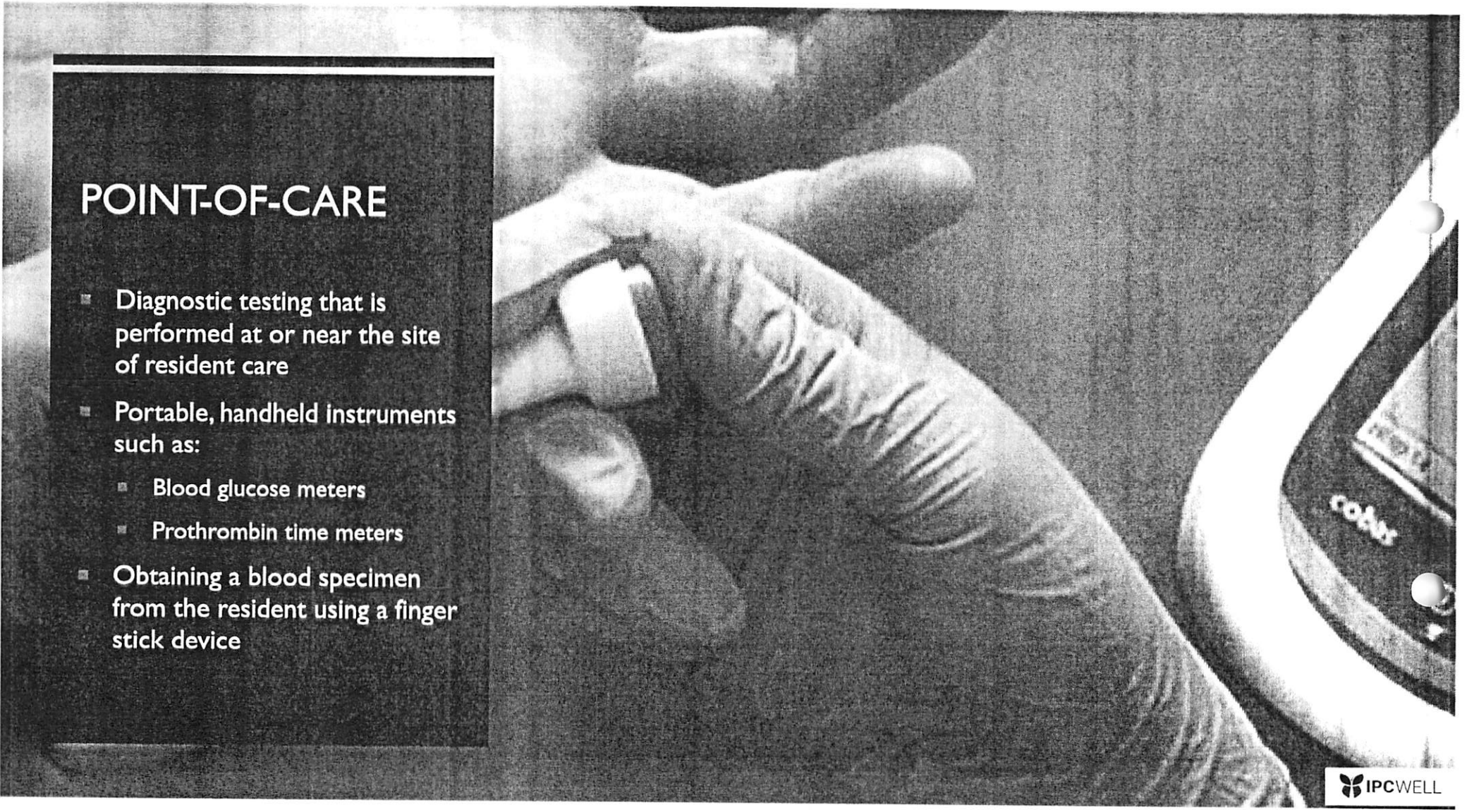
Ineffective Face Mask Bingo



https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/fs-facemask-dos-donts.pdf

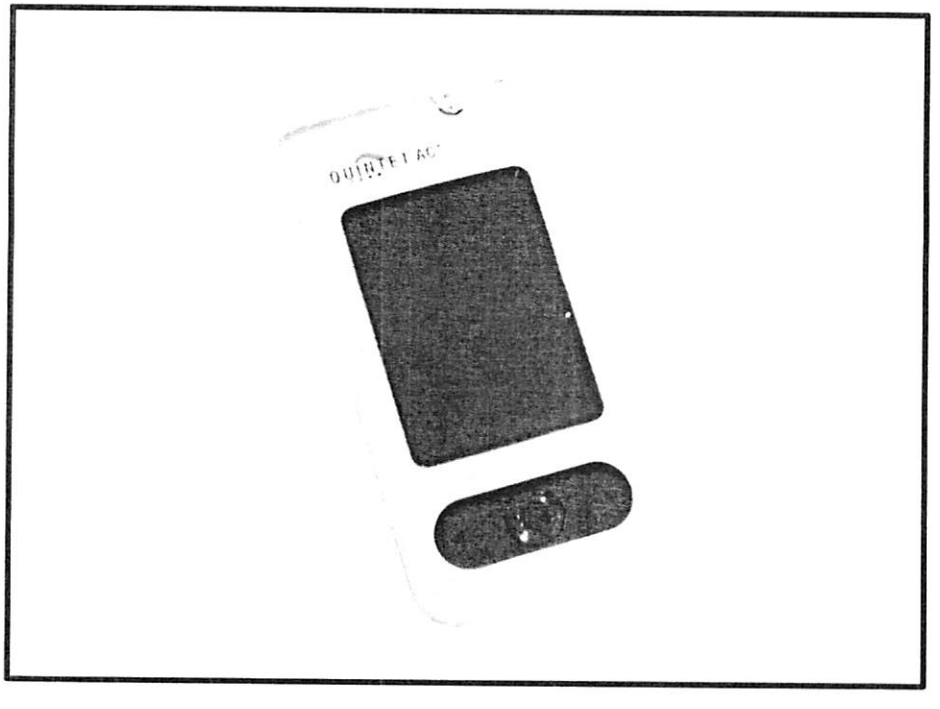
POINT-OF-CARE

- Diagnostic testing that is performed at or near the site of resident care
- Portable, handheld instruments such as:
  - Blood glucose meters
  - Prothrombin time meters
- Obtaining a blood specimen from the resident using a finger stick device



IPCWELL

POINT-OF-CARE IMPLEMENTATION

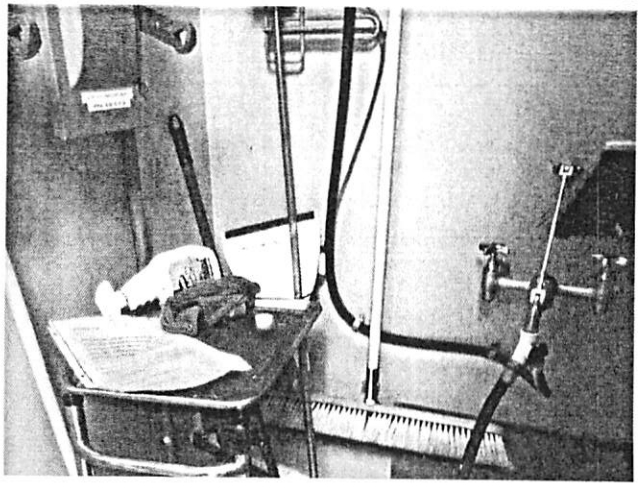


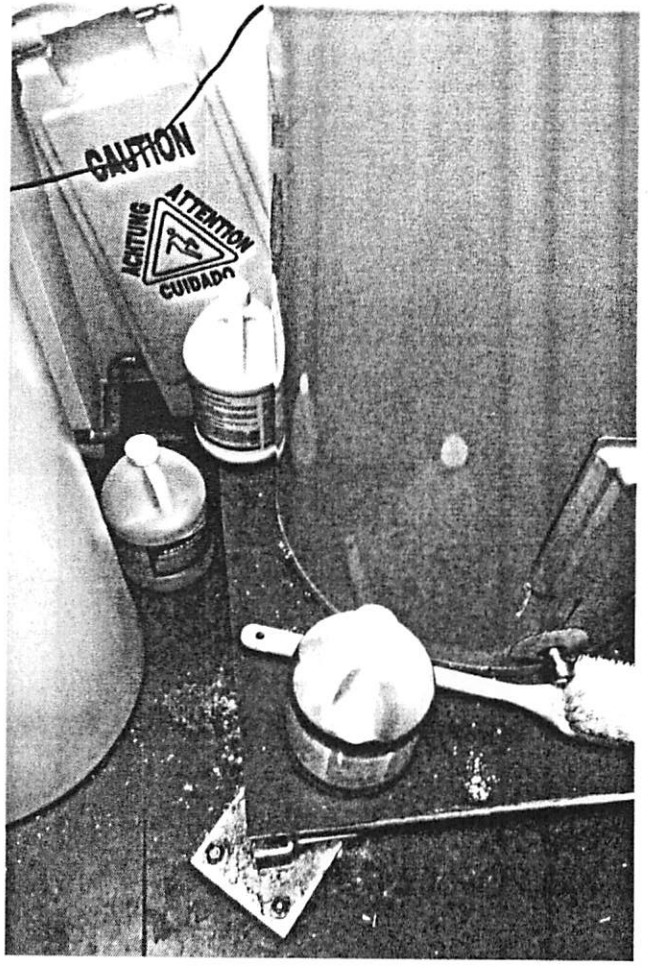
- Ensure not to place any persons at risk for infection
- Never use a device on more than one person
- Performing fingerstick and point of care (assisted blood glucose monitoring) to the extent identified as a resident need based on the facility assessment.
- CDC recommends the use of single-use, auto-disabling fingerstick device
  - Prevents inadvertent reuse of fingerstick devices for more than one person.

https://www.cdc.gov/injectionsafety/pdf/Clinical_Reminder_Fingerstick_Devices_RiskBBP.pdf

ENVIRONMENTAL SERVICES (EVS)

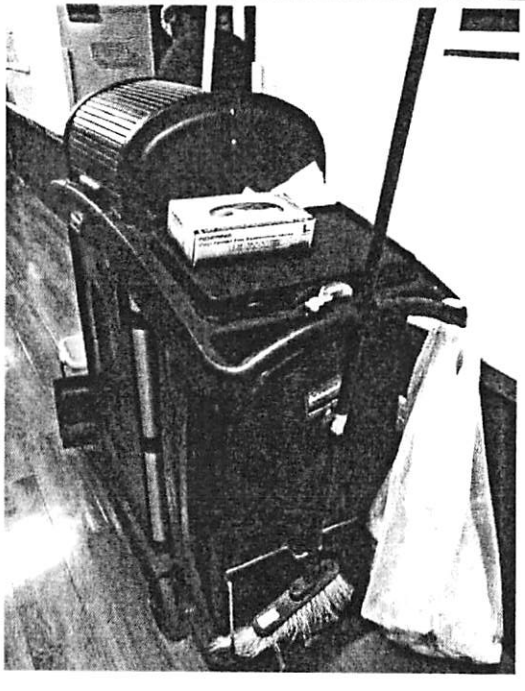
- Environmental sanitation is an integral part of providing a safe and sanitary environment
- Cleaning, disinfection, and storing equipment and supplies is important in preventing the transmission of potential pathogens within the LTCF





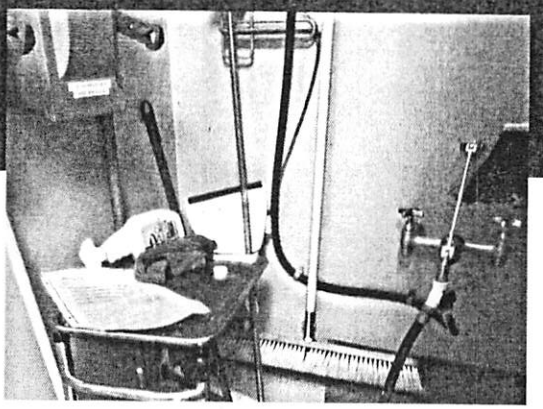
ENVIRONMENTAL SERVICES

- Appropriate PPE
- Contaminating the environment
- IPC training
- Cleaning and disinfectant products
- Supplies (hand towels, hand sanitizer)



SUPPLIES

- Cleaning, disinfection, and storing equipment and supplies is vital to preventing the spread of infections!!



https://www.ncbi.nlm.nih.gov/pubmed/21460503
https://www.ncbi.nlm.nih.gov/pubmed/17540242/

CLEANING VS DISINFECTION

- Cleaning is the physical removal of dirt, body fluids, and other organic matter
- Disinfection destroys potential pathogens on a surface
- What is your "dwell time"?

EVS IMPLEMENTATION

Cleaning Rooms

Order matters: Clean to Dirty, High to Low, in a clockwise or counterclockwise manner

Empty the Trash

Horizontal Surfaces

Vertical Surfaces

Sweep Floor

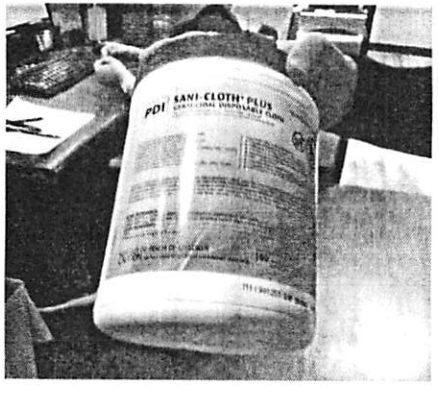
Mop Floor

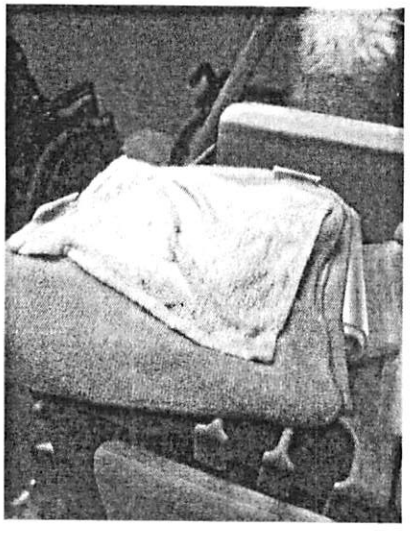
RESTROOMS

- Stock Supplies
- Empty Trash
- Sink and Tub (Horizontal)
- Vertical Surfaces (Walls)
- Clean Toilet
- Sweep Floor
- Mop Floor

IPCWELL

CLEANING AND DISINFECTING PRODUCTS





EPA N-LIST

EPA United States Environmental Protection Agency

Search EPA.gov

Environmental Topics | Laws & Regulations | About EPA

Pesticide Registration

CONTACT US SHARE

- Pesticide Registration Home
- About Pesticide Registration
- Electronic Submission of Applications
- Pesticide Registration Manual
- Fees and Waivers
- Registration Information by Type of Pesticide
- — Antimicrobial Registration

List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19)

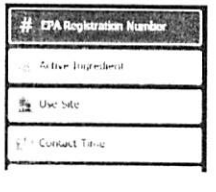
All products on this list meet EPA's criteria for use against SARS-CoV-2, the virus that causes COVID-19.

Finding a Product

To find a product, enter **the first two sets** of its **EPA registration number** into the search bar below. You can find this number by looking for the EPA Reg. No. on the product label.

For example, if EPA Reg. No. 12345-12 is on List N, you can buy EPA

View List N's information in our new tool



https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

IPCWELL

CLEANING CHECKLISTS

[Facility Name]

Environmental Services Checklist for Daily Cleaning of Resident Room

Date:	
Unit:	
Room Number(s):	
Initial of EVS staff (optional)	

Evaluate the following priority sites for each resident room:

Cleaning Task	Cleaned	Not cleaned	Not present in room
High dusting performed			
Use high duster/mop head: wipe ledges (shoulder high and above			
Vents			
Lights (do not high dust over the resident)			
Dust TV: rotate and dust screen and wires			
Damp dust: Cloths and spray bottle of disinfectant for damp wipe			
Ledges (shoulder high)			
Door handles			
Room furniture (bureaus, chairs,			

https://www.cdc.gov/hai/pdfs/toolkits/Environmental-Cleaning-Checklist-10-6-2010.pdf

CDC Environmental Checklist for Monitoring Terminal Cleaning[1]

Date:	
Unit:	
Room Number:	
Initials of ES staff (optional):[2]	

Evaluate the following priority sites for each patient room:

High-touch Room Surfaces[3]	Cleaned	Not Cleaned	Not Present in Room
Bed rails - controls			
Tray table			
IV pole (grab area)			
Call box - button			
Telephone			
Bedside table handle			
Chair			
Room sink			
Room light switch			
Room inner door knob			
Bathroom inner door knob - plate			
Bathroom light switch			
Bathroom handrails by toilet			
Bathroom sink			
Toilet seat			
Toilet flush handle			
Toilet bedpan cleaner			

Evaluate the following additional sites if these equipment are present in the room:

High-touch Room Surfaces[3]	Cleaned	Not Cleaned	Not Present in Room
IV pump control			
Multi module monitor controls			
Multi-module monitor touch screen			
Multi module monitor cables			
Ventilator control panel			

Mark the monitoring method used:

☐ Direct observation ☐ Fluorescent gel ☐ Agar slide cultures
☐ Swab cultures ☐ ATP system

[1]Selection of detergents and disinfectants should be according to institutional policies and procedures
[2]Hospitals may choose to include identifiers of individual environmental services staff for feedback purposes
[3]Sites most frequently contaminated and touched by patients and/or healthcare workers

National Center for Emerging and Zoonotic Infectious Diseases

IPCWELL

LINEN REGULATIONS

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

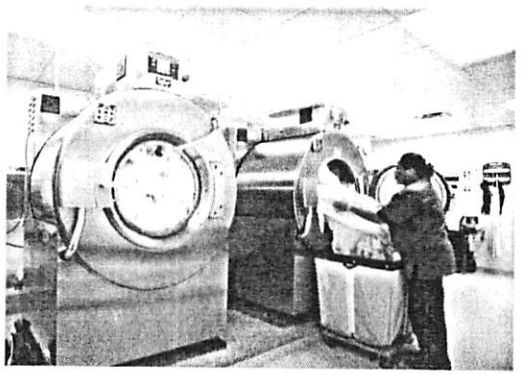
483.80(e) *Facility must develop and follow practices on handling, storing, processing, and transporting laundry. The facility must monitor to ensure that the laundry practices are implemented, any deviations from practices must be identified, and corrective actions are put in place.*

Laundry includes resident's personal clothing, linens, (i.e., sheets, blankets, pillows), towels, washcloths, and items from departments such as nursing, dietary, rehabilitative services, beauty shops, and environmental services. Laundry services may be provided onsite or the facility may have written agreement in place for offsite laundry services. Regardless of the location where laundry is processed, the facility must ensure that all laundry is handled, stored, processed and transported in a safe and sanitary method.

LINEN MANAGEMENT

- Linen must be processed in a way that not only kills germs but also does not spread germs from dirty to clean linens (hot water)

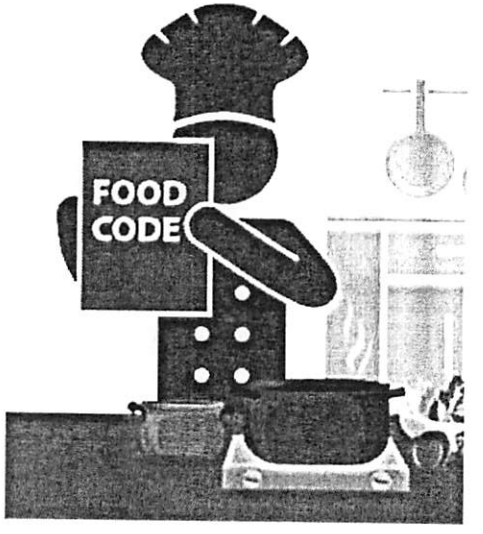
- Cart covers should be inspected for any contamination with dirt or debris and removed or replaced as needed (how often are they cleaned)?

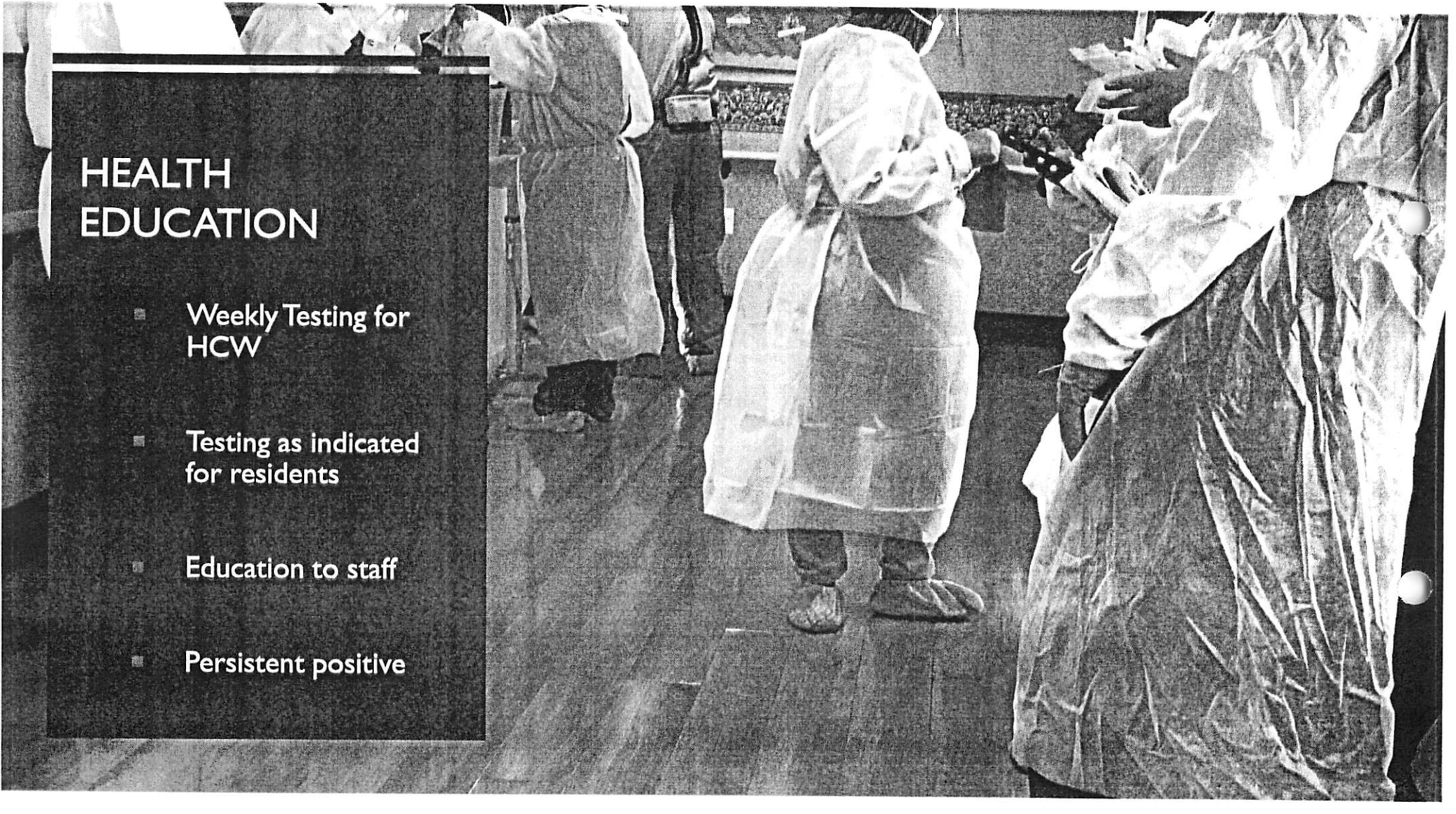


https://www.infectioncontroltoday.com/personal-protective-equipment/infection-control-today-032002-follow-standard-precautions-when

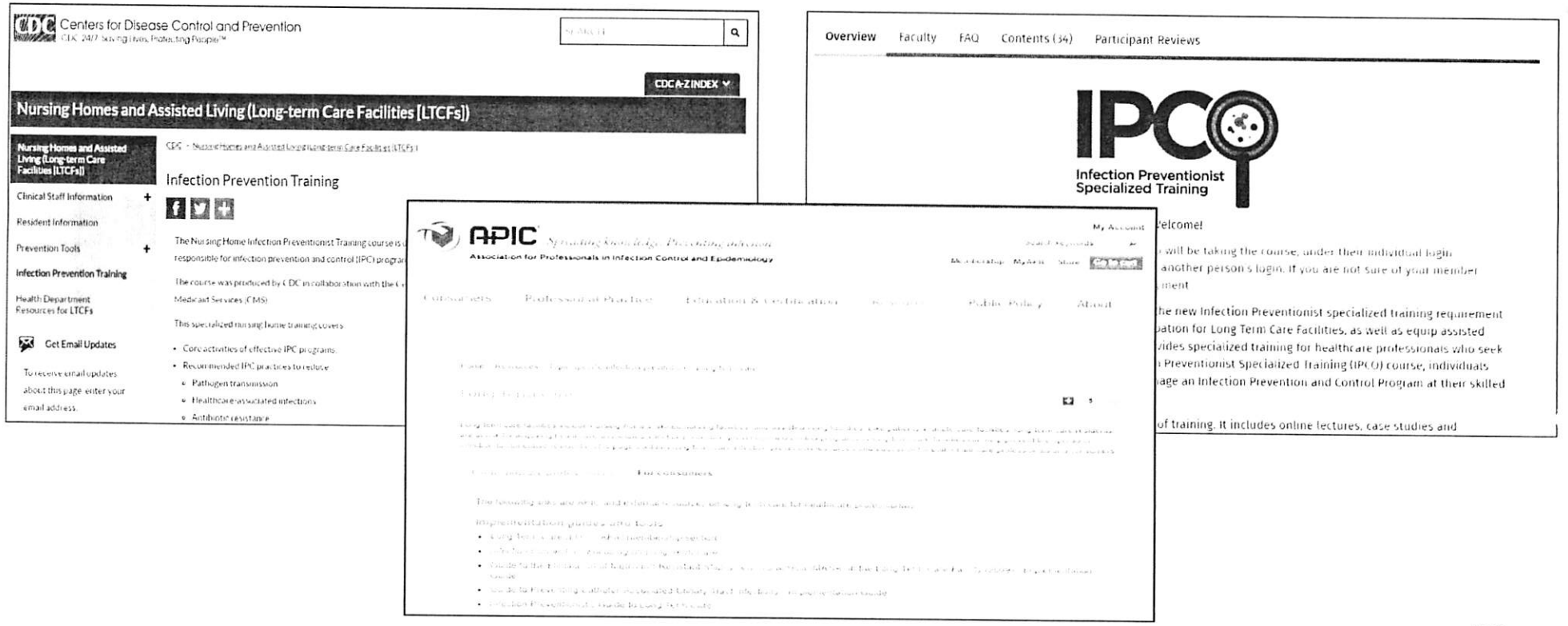
FOOD SERVICES

- Dietary/food staff can be a source for ongoing transmission of illness from contaminated food
- Masks to be worn by all food service workers covering mouth and nose at all times
- Remind staff not to touch the front of the mask while temporarily removing the mask, preparing food, washing dishes or other activity
- If the mask is soiled, damaged or persons are having trouble breathing throw it away in a closed trash can and replace it with a new mask
- Exclude ill dietary staff from work for 72 hours after diarrhea/vomiting have stopped
- Clean and sanitize all kitchen and dining area surfaces with an EPA approved product




HEALTH EDUCATION
Weekly Testing for HCW
Testing as indicated for residents
Education to staff
Persistent positive

ADDITIONAL LONG-TERM CARE IP TRAINING



QUESTIONS