Medicare/Medicaid Public Records Documents Only

Survey event:9X1V

Facility: GRANITE CREEK HEALTH & REHAB

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9X1V12

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: **6** (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): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
An offsite revisit survey event #9X1V12 for complaint investigation was conducted on 8/4/2023. No deficiencies were cited.

17. SURVEYOR SIGNATURE
Estrella Gies BC, by: Monica Miller
Date : 08/04/2023 (L19)

18. STATE SURVEY AGENCY APPROVAL
Monica Miller Estrella Gies
Date: 10/05/2023 (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

October 5, 2023

Morgan Cooper, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Cooper:

On August 4, 2023, an offsiterevisit survey was conducted for your facility by the Arizona Department of Public Health, Licensing and Certification Bureau, to determine if your facility was in compliance with federal participation requirements at the time of the follow-up investigation to Complaint #9X1V12.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567) indicates, based on your Plan of Correction, 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,

Monica Miller

Monica Miller
Program Specialist

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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 08/04/2023

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 offsite follow-up survey was conducted on 8/4/2023. There were no deficiencies cited.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
035131		8/4/2023

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0602 Reg. # 483.12 LSC	Correction Completed 07/18/2023	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 07/18/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 07/18/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) EG	DATE 08/04/2023	SIGNATURE OF SURVEYOR Estrella Gies	DATE 08/04/2023
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

July 19, 2023

Morgan Cooper, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear . Cooper:

On **June 9, 2023**, a Medicare abbreviated survey, **#9X1V11,** was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaints investigations may have also been conducted.

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

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

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

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

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **July 29, 2023**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **July 29, 2023** may result in the imposition of remedies.

The POC must be signed and dated by an official facility representative. Please send your POC by email to the following:

ltc.licensing@azdhs.gov
SUBJECT LINE: the name of your facility and POC

Your PoC must contain the following:

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

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

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

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

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

- Please provide all in-service records to include:

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

Allegation of Compliance

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

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of July 24, 2023**.**

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

Recommended Remedies

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

Recommending to CMS Civil Money, effective June 9, 2023
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on June 9, 2023. If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. The CMS Regional Office must terminate your provider agreement if substantial compliance has not been reached by **December 6, 2023**.

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

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

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory Denial of Payment for New Admissions effective **September 7, 2023**. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit.
This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid} The Medicare and Medicaid programs will make no payment for residents whose plans of care begin on or after the DPNA effective date.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an

administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

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

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

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

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

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

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

Informal Dispute Resolution

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

An informal dispute resolution process will not delay the effective date of any enforcement action. **Please note: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **July 29, 2023**, licensure and/or recertification may be denied. 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,

Megan Whitby
Assistant Deputy Director, Public Licensing
Bureau of Long Term Care Licensing

MW:eg

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	C 06/09/2023

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 complaint survey was conducted on May 27 through June 9, 2023 for the investigation of the following intake #s: AZ00177307, AZ00177379, AZ00177845, AZ00178425, AZ00178701, AZ00178742, AZ00179756, AZ00181079, AZ00171525, AZ00182110, AZ00182760, AZ00184938, AZ00186905, AZ00187241, AZ00189808, AZ00189797, AZ00189921, AZ00190194, AZ00190183, AZ00190327, AZ00190388, AZ00190779, AZ00190898, AZ00192716, AZ00192738, AZ00192994, AZ00193068, AZ00193066, AZ00193124, AZ00193348, AZ00193639, AZ00193712, AZ00194116, AZ00194891, AZ00195007, AZ00195131, AZ00195318, AZ00195320, AZ00195662, AZ00195854 and AZ00195832. The following deficiencies were cited:	F 000	*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.* (Initials)	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documents and policy, the facility failed to ensure two residents (#85 and #24) were free from drug diversion. The deficient practice could result in misappropriation of resident's medication.	F 602	**F 602** **Corrective action for residents found to have been affected by this deficiency:** Resident #85's morphine was reordered. The resident is no longer in the facility. Resident #24's morphine was reordered and is still a current resident at the facility. **Corrective action for residents that may be affected by the deficiency:** All residents have a potential to be affected. A facility wide sweep was conducted. All narcotic medication were accounted for and visually inspected.	7/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ED	7/28/23

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 06/09/2023

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 602	Continued From page 1 Findings include: -Resident #85 was admitted on July 8, 2022 with diagnoses of malignant neoplasm of bladder and colon. A physician order dated November 21, 2022 included morphine sulfate (opioid) solution 20 mg(milligrams)/mL (milliliter) give 0.5 mL by mouth every 2 hours as needed for pain 1-10. A quarterly Minimum Data Set (MDS) assessment dated January 28, 2023 included the resident was able to express ideas and wants and was able to understand others. The assessment also included the resident had received scheduled and as-needed pain medication and he had limited day to day activities in the last 5 days due to pain with the highest pain being 7/10. -Resident #24 was admitted on September 13, 2019 with diagnoses of chronic obstructive pulmonary disease and fibromyalgia. A physician's order dated February 19, 2023 included morphine sulfate solution 20mg/mL give 10 mg by mouth every 2 hours as needed for pain 1-10. A quarterly MDS assessment dated March 19, 2023 included the resident was rarely or never understood and was moderately impaired for decision making regarding tasks of daily life. Per the assessment, the resident received as-needed pain medication and that highest pain was 8/10 in the last 5 days.	F 602	Additionally, liquid narcotics were inspected, pulled from carts and new ones were reordered. No additional concerns were noted. No additional residents were identified to be potentially affected. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were in serviced on proper narcotic counting, tracking, documentation, removal procedures, and reporting suspected drug diversion, misappropriation, and abuse. All staff were in serviced on the facility's abuse reporting policy to include EJA and abuse prevention. The ED and/or designee will review grievances with the department heads in stand-up meeting, Monday-Friday to identify any concerns and ensure appropriate follow-up has occurred. **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:** An audit was created to monitor for misappropriation of narcotic medications and were done Monday through Friday for 2 weeks, then weekly for one month, then randomly for 6 weeks. Findings and analysis will be reported to the QAA Committee for 3 months. Responsible: Abuse coordinator and Director of Nursing or designee.	7/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 602	Continued From page 2 A 5-day report on March 22, 2023 included that residents #85 and #24 were potentially affected by misappropriation of liquid morphine. Per the documentation, the liquid morphine in question was compared with other liquid morphine in the facility and was determined to be of a different color and consistency based on visual inspection. It also included that a pharmacist was interviewed and the pharmacy recommended that visual inspection was enough to allege diversion. Per the facility report this allegation was unable to be substantiated; and that, the investigation was inconclusive. Further, the report included that facility interviews indicated that staff had no prior experiences in the building with misappropriation. However, an interview was conducted on May 27, 2023 at 3:07 p.m., with a licensed practical nurse (LPN/staff #37) who stated that there was a nurse who was making medications disappear from another staff's (#50's) cart. She said that she had written "do not use this card" because it was the wrong medication and it just disappeared. She said that she noticed that residents who do not usually take their opioid medications such as morphine, were the ones that were taken and disappear. The LPN stated that she made copies of the narcotic sheets and had informed the Director of Nursing (DON) about it. An interview with a registered nurse (RN/staff #50) was conducted on May 27, 2023 at 2:43 p.m. The RN said that that facility did have a registry nurse; and that, the morphine located in the 400 hall was the wrong color. She stated that the facility placed the registry nurse on the "do	F 602		7/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTER	1045 SCOTT DRIVE PRESCOTT, AZ 86301

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F 602	Continued From page 3 not return list" after the several nurses complained multiple times about morphine medications having wrong color and disappearing from the medication carts during the shift of the alleged registry nurse. In an interview with a RN (staff #3) conducted on May 28, 2023 at 1:18 p.m., the RN stated that she found the morphine with the wrong color; and, she wrote this on the narcotics sheet as "unidentifiable liquid do not administer". She said the reported to the DON that the morphine was the wrong color on March 19, 2023 at 7:15 p.m. An interview with a pharmacist was conducted on June 7, 2023. The pharmacist stated that the liquid morphine sulfate was either light blue or blue green in appearance; and that, he would want to check into it if this medication were a lighter color than expected. He said that it could be watered down and that while color varied, he would still consider this as misappropriation. During an interview conducted with the DON (staff #8) on June 9, 2023 at 10:49 a.m., the DON stated that her expectation was for staff to report immediately to her or the administrator and misappropriation issues especially if it involved controlled substances. She stated that in the case of controlled substances being altered or missing, she would get interviews from staff members, notify family and residents and obtain new medications and replace the medication. Unfortunately, the DON stated that when talking with pharmacy, there was no way to definitely say that the medication had been misappropriated and/or no way to prove misappropriation as the staff who was doing it	F 602		7/18/23

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	035131	A. BUILDING _____ B. WING _____	C 06/09/2023

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F 602	Continued From page 4 would want to act with an abundance of caution. She said that any concerns reported to her by her staff would be acted on immediately. She said that the staff did replace the medication and reported it to their hospice provider and medical director. The facility policy on Abuse: Prevention of and Prohibition Against revealed that it is their policy that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.	F 602		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility policy and State Agency (SA) complaint database, the facility failed to ensure environment was free of accident hazards for one resident (#62). The deficient practice could result in resident sustaining injury. Findings include: Resident #62 was admitted on May 3, 2019 with diagnoses of spinal stenosis, fibromyalgia and osteoporosis.	F 689	**F 689** **Corrective action for residents found to have been affected by this deficiency:** Resident #62 was readmitted to the facility with an updated treatment plan. The resident has been assessed by the attending physician, and the care plan has been updated. **Corrective action for residents that may be affected by the deficiency:** All residents have a potential to be affected. A facility wide audit was conducted for potential accidental fall hazards and appropriate fall prevention interventions in place. No other resident was identified as having falls related to accidental fall hazards.	7/18/23

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F 689	Continued From page 5 A care plan dated May 3, 2019 revealed the resident was at risk for falls related to history frequent falls; and, required extensive assist of 1-2 with the completion of Activities of Daily Living (ADLs) and active functional mobility skills. A quarterly Minimum Data Set (MDS) assessment dated February 4, 2023 the resident was cognitively intact; and, required one-person physical assistance supervision for transfers. A care plan dated February 24, 2023 revealed the resident had osteoporosis. Interventions included to educate resident, family/caregivers on safety measures that need to be taken in order to reduce risk of falls. The fall care plan was revised on March 4, 2023 to include an intervention for staff to complete education on proper placement of food tray in room and to ensure tidiness of items. Hospital record dated March 4, 2023 included the resident had a fall, came into the ER (emergency room) and was found to have a left femoral neck hip fracture; and that, the fracture was surgically repaired. An interdisciplinary team (IDT) note dated March 7, 2023 revealed that the IDT met to discuss the resident secondary to fall on March 4, 2023. Per the documentation, a staff heard the crash of dishes and the resident called out; and when the staff entered the resident's room, the resident was laying on her left side at the foot of the bed. It also included that the resident was assessed for injury, vital signs were taken, and the resident was assisted to her chair. According to the	F 689	**Measures that will be put into place to ensure that this deficiency does not recur:** Inservice training was given to all staff on accidental fall hazards, fall interventions and ADL assistance to prevent residents from potential falls. IDT will meet Monday through Friday to review the fall management system, to include residents at risk for falls and residents that have had falls. **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:** Audits of the fall management system will be done Monday thru Friday for 2 weeks, then biweekly for 4 weeks, then randomly for 1 month. Findings and analysis will be reported to the QAA Committee for three months. Responsible: DON or designee.	7/18/23

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F 689	Continued From page 6 documentation, the resident was able to walk to her chair with walker and staff assistance but reported pain in her left hip that continued to increase. The note included that the resident was sent to the hospital for further evaluation through EMS (emergency medical services); and that, the resident was admitted for hip fracture. Further, the note included that staff were to receive education on proper placement of food tray in room and overall tidiness of room. A 5-day MDS assessment dated March 14, 2023 included the resident had a fracture related to a fall; and, required extensive 2 plus person assistance for transfers. The SA complaint database dated May 12, 2023 included an allegation that the staff had put the resident's meal tray on the resident's wheelchair seat; and, the resident went to sit down in her wheelchair not knowing meal tray was in her seat. The report included that the resident and the meal tray hit the floor resulting in the resident breaking her left hip. An interview was conducted on May 28, 2023 at 1:52 p.m. with a licensed practical nurse (LPN/staff #27) who stated the staff who brought the tray in the resident's room placed the tray on the resident's wheelchair put it on the resident's wheelchair; and that, resident #62 sat on a meal tray. The LPN stated that probably the resident's tray table was full. An interview was conducted with a certified nursing assistant (CNA/staff #15) on June 7, 2023 at 8:59 a.m. The CNA stated that staff were not supposed to put the meal tray on the chair;	F 689		7/18/23

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F 689	Continued From page 7 and that, the meal tray should go on the side table, and the lid on the counter. She said that if there was no room on the resident's tray table, she would set the tray with the rest of the trays or set it down by the sink until she can find a tray table. The CNA stated that she would not put the meal tray in the chair. Regarding the incident with resident #62, the CNA stated that someone placed the meal tray in seat of the wheelchair, the resident did not know and she fell. During an interview with the Director of Nursing (DON/staff #8) conducted on June 9, 2023 at 10:49 a.m., the DON said that her expectation was that when staff delivers food to resident rooms, they would greet the resident, place the tray where the resident can reach it and get the tray. She said that staff should never place the tray on the resident's wheelchair unless the resident requested it. She said she would not want the tray to be placed in the chair because of increased risk of falls and injury. Regarding resident #62, she stated that the resident had been at the facility for some time, was able to make her needs known and was well known to the facility. The DON stated that at the time of the incident, the meal tray was placed on the resident's chair; the resident went to sit on the chair and slipped off of the chair due to the tray on the chair. She said that this did not meet her expectations. The facility policy on Fall Management System included that the facility was committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible and that each resident is assisted in attaining or maintaining their highest	F 689		7/18/23

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F 689	Continued From page 8 practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents.	F 689		
F 880 SS=E	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;	F 880	**F 880** **Corrective action for residents found to have been affected by this deficiency:** Resident #57 remains in the facility and has been examined by the attending physician. She is receiving care and services according to her plan of care. **Corrective action for residents that may be affected by the deficiency:** All residents have a potential to be affected. A full in- house audit was conducted to identify potential exposure from staff related illnesses. No other residents were identified as affected. **Measures that will be put into place to ensure that this deficiency does not recur:** In-services were given to all staff on call off procedures for illnesses, reporting illness related symptoms to the Infection Prevention nurse (IP), and Director of Nursing (DON), and return to work policies and procedures. On-going tracking of staff related illnesses will be completed by staffing coordinator and will be reviewed by the infection preventionist.	7/18/23

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F 880	Continued From page 9 (ii) When and to whom possible incidents of 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 clinical record review, resident and staff interviews and facility policy review, the	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:** Audits of staff call offs and reports of staff related illnesses will be done Monday thru Friday for 2 weeks, then Biweekly for 4 weeks, then randomly for 1 month. Findings and analysis will be reported to the QAA Committee for three months Responsible: DON or designee, Staffing Coordinator, Infection preventionist.	7/18/23

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F 880	Continued From page 10 facility failed to ensure that staff were not allowed to work while they were sick. The deficient practice could result in transmission of infection to residents and staff. Findings include: Resident #57 was admitted on April 18, 2022 with diagnoses of fibromyalgia, post-traumatic stress disorder and Major Depressive Disorder. An annual Minimum Data Set (MDS) assessment dated April 22, 2023 included the resident had intact memory and was independent to make the decisions for tasks of daily living. The assessment also included that the resident did not show signs of delirium, hallucinations or delusions and had not exhibited behavioral symptoms. An interview with resident #57 was conducted on May 28, 2023 at 2:23 p.m. Resident #57 stated that she had seen employees working sick; and that, the certified nursing assistant (CNA/staff #81) caring for her did not look good and she asked that CNA who responded with a sigh and did not answer. She said the CNA (staff #81 was very careful not to say anything; however, other staff who also were sick had told her that it was ridiculous that when other staff would call off, facility management would tell staff who were sick to come in sick because others have called in. An interview was conducted on March 27, 2023 at 3:32 p.m. with a CNA (staff #81) who stated that she was sick during her workday on Monday; and, she thought she ate something that didn't	F 880		7/18/23

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F 880	Continued From page 11 agree with her. She said she spoke with the staffing coordinator who told her that she must find her own coverage or she cannot go home. She stated that she was changing residents but had to run because she was having diarrhea. The CNA stated that she had to resort to wearing pull ups because she could not control her bowels; despite that, she was not allowed to go home. The CNA stated that she was still very sick on Tuesday which was her day off. She said she called the staffing coordinator to inform that she would not be able to make it to her Wednesday shift because she was going to the emergency room. The CNA said that the staffing coordinator told her that no one goes to the ER (emergency room) for diarrhea. The CNA said that she was given 2 types of antibiotics for bacterial colitis; and that, the hospital gave her a note saying that she could not work until the 26th. However, when she told the Director of Nursing (DON/staff #8) about this, the DON told her that she was abandoning her residents. In an interview with a registered nurse (RN/staff #3) conducted on May 28, 2023, the RN stated that she was the nurse on duty when a CNA (staff #42) almost passed out. The RN said that the CNA was nauseous and throwing up; and when she called management to get more relief, the CNA was never sent home. An interview was conducted on May 28, 2023 at 1:52 p.m. with a licensed practical nurse (LPN/staff #27) who stated that he had worked with staff who were ill during the shift. The LPN stated that when calling out, staff would contact the staffing coordinator at least 2 hours ahead of time to give her notice; and that, staff performs	F 880		7/18/23

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F 880	Continued From page 12 self-testing for COVID. The LPN said that the other day he worked with a CNA (staff #42) who was nauseous; however, he did not know if the CNA called management which was a policy when staff are sick. In an interview with a CNA (staff #49) conducted on June 9, 2023 at 10:19 a.m., the CNA stated that the facility management was making their staff work when staff were sick. The CNA stated that management instructed staff that if staff were sick they had to find their own coverage for their shift. The CNA said that the facility did not have a lot of core staff; however, the staff cannot call agency staff either. So, the CNA stated that staff just work even when they were sick. During an interview with the DON (staff #8) conducted on June 9, 2023 at 10:49 a.m., the DON stated that the expectation was that if a staff member was feeling sick then they are asked about their symptoms of COVID and if they have tested. However, the DON stated that the staff do not work while they are sick. She said that she had not received reports that staff were working ill in the building. The DON stated that she had provided all of the policies for staff working sick. However, review of the policies provided to the survey team revealed no policy that included that facility prohibited staff from working while sick.	F 880		7/18/23

ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

October 5, 2023

Morgan Cooper, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Re: Complaint Intake #AZ00177307, #AZ00177308, #AZ00195855, #AZ00195854, #AZ00195320, #AZ00195321, #AZ00178742, #AZ00195131, #AZ00195132, #AZ00195007, #AZ00195009, #AZ00194896, #AZ00194891, #AZ00194120, #AZ00194116, #AZ00193639, #AZ00193640, #AZ00193348, #AZ00193350, #AZ00193068, #AZ00193069, #AZ00192997, #AZ00192994, #AZ00192738, #AZ00192739, #AZ00190389, #AZ00191420, #AZ00190898, #AZ00190899, #AZ00184939, #AZ00184938, #AZ00190388, #AZ00177379, #AZ00190194, #AZ00192739, #AZ00189809, #AZ00189808, #AZ00177380, #AZ00177846, #AZ00177845, #AZ00178703, #AZ00178701, #AZ00178425, #AZ00178427, #AZ00182110, #AZ00182112, #AZ00178744, #AZ00181525, #AZ00181080, #AZ00179758, #AZ00179756, #AZ00187241, #AZ00187242, #AZ00186905, #AZ00186906, #AZ00181079, #AZ00181526, #AZ00195662, #AZ00193712, #AZ00193066, #AZ00192716, #AZ00190779, #AZ00190327, #AZ00190183, #AZ00189921, #AZ00189797, #AZ00182760
Investigation #9X1V11

Dear Mr. Cooper:

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

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

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

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

Sincerely,

Monica Miller

Monica Miller
Program Specialist
Bureau of Long Term Care Licensing

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 5, 2023

Morgan Cooper, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Re: Complaint Intake #AZ00195832, #AZ00195833, #AZ00195319, #AZ00195318, #AZ00193124, #AZ00193126
Investigation #9X1V11

Dear Mr. Cooper:

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,

Monica Miller

Monica Miller
Program Specialist
Bureau of Long Term Care Licensing