Medicare/Medicaid Public Records Documents Only

Survey event # A3PR

Facility: GRANITE CREEK HEALTH & REHAB CTR

Revised 7-2020

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: A3PR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0057

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

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

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

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

6. DATE OF SURVEY **09/23/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Granite Creek Health and Rehabilitation was found to be out of compliance with federal regulations based on an annual survey conducted on 9/23/2021. Granite Creek Health and Rehabilitation is back in compliance with federal regulations based on an allegation of compliance and acceptable plan of correction with evidence of compliance, revisit survey completed on 10/19/2021 State Agency recommended recertification.

17. SURVEYOR SIGNATURE Date :
for Lisa Bashford, Surveyor Lead 10/19/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Sandy Farmer 10/19/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
10301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 20, 2021

Important Notice - Please Read Carefully

Joaquin Martinez
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Re: Provider Number 035131

Dear Mr. Martinez:

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

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

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE/sf

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

October 20, 2021

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Joaquin Martinez, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Martinez:

On October 19, 2021, an offsite 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 participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations based on an allegation of compliance and acceptable plan of correction.

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

Sincerely,

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 10/19/2021

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 offsite follow-up survey was conducted on October 19, 2021. 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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035131 Y1	A. Building B. Wing Y2	10/19/2021 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0552	Correction	ID Prefix F0580	Correction	ID Prefix F0658	Correction
Reg. # 483.10(c)(1)(4)(5)	Completed	Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	11/12/2021	LSC	11/12/2021	LSC	11/12/2021
ID Prefix F0677	Correction	ID Prefix F0732	Correction	ID Prefix F0757	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(d)(1)-(6)	Completed
LSC	11/12/2021	LSC	11/12/2021	LSC	11/12/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	ME	10/19/21	Mint Cruz	10/19/21
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 9/23/2021

☐ 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

October 20, 2021

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Joaquin Martinez, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Martinez:

On October 18, 2021, an offsite Life Safety Code revisit was conducted at your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations based on an allegation of compliance and acceptable plan of correction.

Enclosed is the **Life Safety Code**, 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
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 **01 - MAIN BUILDING 01** B. WING _____	R **10/18/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Based on an acceptable plan of correction submitted to the Arizona Department of Health Services on October 18, 2021 for standard level deficiencies cited during the Medicare and Medicaid (CMS) Life Safety Code survey, no on-site follow up survey will be conducted for Event # A3PR22.	{K 000}		

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035131 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/18/2021 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0923	Correction Completed 10/18/2021	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	AV	10/18/2021	Anthony Valenti	10/18/2021
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
9/24/2021	☐ 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

October 7, 2021

Receipt Of This Notice Is Presumed To Be -10/07/2021
Important Notice - Please Read Carefully

Joaquin Martinez, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Martinez:

On **September 23, 2021**, a Medicare recertification survey, #A3PR11, 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 **October 17, 2021**. You must include all pages of the Statement of Deficiencies when submitting your PoC.
Failure to submit an acceptable PoC by **October 17, 2021** 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 December 7, 2021.

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 September 23, 2021
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on September 23, 2021. 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 **April 21, 2022**.

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 **January 21, 2022**. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit.
This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid} The Medicare and Medicaid programs will make no payment for residents whose plans of care begin on or after the DPNA effective date.

FILING AN APPEAL

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

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

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

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

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

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

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

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

Informal Dispute Resolution

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

An informal dispute resolution process will not delay the effective date of any enforcement action. **Please note: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**
Retain a copy of the PoC for your files. If the PoC is not received by this Office by **October 17, 2021**, 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,

Diane Eckles

Diane Eckles
Bureau Chief

DE:mm

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 _____	09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Recertification survey was conducted 9/20/2021 through 9/23/2021. The census was 72. The following deficiencies were cited:	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, and facility policy, the facility failed to ensure that two residents (#10 and #5) and/or their representatives were informed of the risks and benefits of psychoactive medications prior to the administration of the medications. The sample size was 6 residents. The deficient practice could result in residents and/or resident representatives not having a clear understanding of the risks and benefits of medications.	F 552	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did in fact exist; rather the facility is filing this document in order to comply with its obligations as provider participating in the Medicare/Medicaid program(s). The following Plan of Correction is intended to serve as a credible allegation of our intent to correct the practices identified as deficient and to implement the corrections as stated. JM (Initials) **F 552** **Corrective action for residents found to have been affected by this deficiency:** Informed consent for psychotropic medication has been obtained for residents # 10 and #5. **Corrective action for residents that may be affected by the deficiency:** A full house audit has been completed for residents on any psychotropic medication to ensure all have informed consent for use.	11/12/21

LONG TERM CARE
150 N. 18TH AVE # 440
PHOENIX, AZ 85007

OCT 15 2021

ARIZONA DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
LICENSING

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

Administrator | 10/15/2021

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 _____	09/23/2021

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 552	Continued From page 1 Findings include: -Resident #10 was admitted to the facility on March 29, 2021 with diagnoses that included major depressive disorder, chronic pain, type 2 diabetes and ischemic cardiomyopathy. The quarterly Minimum Data Set (MDS) assessment dated July 6, 2021 revealed that the resident could not complete a Brief Interview for Mental Status (BIMS) due to not being able to be understood. Both the resident's short term and long term memory were assessed to be okay. The MDS further revealed that the resident had received an antidepressant medication daily in the 7-day look-back period of the assessment. Review of the care plan, revised August 29, 2021, revealed that the resident was receiving an antidepressant medication. An intervention for this focus area included that the resident and family were to be educated on the risks and benefits and side effects of taking the antidepressant medication. Review of the physician orders revealed an order dated August 30, 2021 for Prozac (an antidepressant medication and also a psychoactive medication) 20 milligrams (mg) for depression. Review of the resident's Medication Administration Records (MAR) for June through September 2021 revealed the Prozac was administered as ordered. Review of the clinical record revealed no evidence that the resident and/or the resident's	F 552	**Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses have been re-inserviced regarding obtaining informed consent prior to administering any psychotropic medication, and to obtain the consent promptly when receiving the order. Audit tools and audit schedules have been developed. **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:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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 _____	09/23/2021

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 552	Continued From page 2	F 552		

family had been provided information about the risks and benefits of the antidepressant medication prior to receiving the medication.

An interview was conducted on September 23, 2021 at 12:28 p.m. with the medical records supervisor (staff #56). She stated that she had reviewed the resident's clinical record and that there were no signed informed consents in the record for psychoactive medications. She stated that she was not aware of the reason that no consents were found in the record.

On September 23, 2021 at 1:01 p. m., an interview was conducted with the Director of Nursing (DON/staff #10). She stated the medication informed consents are completed by admissions or by a nurse. She stated that there had been some staff turnover but she was unsure why this resident did not have an informed consent in the record.

-Resident #5 was admitted to the facility on September 13, 2019 with diagnoses that included anxiety disorder and bipolar disorder.

Review of the psychotropic medication care plan, dated September 2, 2021, revealed that the resident was receiving antipsychotic medication related to bipolar disorder as evidenced by mood disturbances. Interventions included to administer the medication as ordered and to educate the resident and the resident's family about the risks, benefits, and the side effects of the medication.

Review of the annual MDS assessment dated September 21, 2021, revealed the resident scored a 12 on the BIMS indicating moderate cognitive impairment. The MDS included that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING _____ B. WING _____	09/23/2021

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 552	Continued From page 3 resident received antipsychotic medications daily during the 7-day look-back period of the assessment. A review of the physician's orders for September 3 through 24, 2021 revealed multiple orders for Risperdal (an antipsychotic/psychotropic medication) for bipolar disorder as evidenced by mood disorder. The dose of the medication changed several times and ranged from 0.25 mg to 1.0 mg. Review of the MAR for September 3 through 24, 2021 revealed the resident received the Risperdal as ordered. Review of the clinical record revealed no evidence that the resident and/or the resident's family had been informed of the risks and benefits of the antipsychotic medication Risperdal prior to receiving the medication. An interview was conducted with a Licensed Practical Nurse (LPN/staff #11) on September 23, 2021 at 8:40 a.m., who stated that the facility process is to obtain informed consents prior to administering psychotropic/antipsychotic medications. She further stated that when an antipsychotic medication is prescribed, the nurse would be responsible for obtaining the medication consent. She stated that the consent is completed on paper, and then given to medical records to scan into the resident's Electronic Medical Record (EMR). She stated that Risperdal is a psychotropic medication and would require a consent. She then reviewed the medical record and stated that the resident has been receiving Risperdal and has a current order for it. She further stated that she could not locate a consent	F 552		

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 _____	09/23/2021

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 552	Continued From page 4 for Risperdal in the medical record. She also stated that after reviewing the MAR for September 2021, Risperdal had been administered without a consent. She also stated that this did not meet facility expectations or policy and the risk would be that the resident may not be educated on the risks and side effects of Risperdal. An interview was conducted on September 23, 2021 at 10:11 a.m. with the medical record supervisor (staff #56), who stated that the nurses are responsible to complete medication consents and then would give them to medical records to scan into the resident EMR. She also stated that she keeps the original consents in a file in her office for all residents. She reviewed the medical record and stated that there was no consent for Risperdal in the resident's EMR. She also stated that she did not have one in her office files. An interview was conducted with the DON (staff #10) on September 23, 2021 at 10:18 a.m., with a corporate clinical resource registered nurse (staff #100) in attendance. The DON stated the facility expectation regarding new physician orders for psychotropic/antipsychotic medications is to inform and educate the resident about the medication and to review the consent and obtain a signature. She further stated that if the resident agrees, they would then start administering the medication. The DON then stated that the completed consents are given to medical records to scan into the EMR. She reviewed the physician's orders in the EMR and stated that the resident has been receiving Risperdal, and that there should be a consent in the EMR for this medication. She further reviewed the medical record and stated that there was not a consent in	F 552		

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 _____	09/23/2021

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 552	Continued From page 5 the EMR for Risperdal. An interview was conducted on September 23, 2021 at 11:07 a.m. with a LPN (staff #81), who stated that she is responsible for ensuring the psychotropic consents are completed when they receive a new order. She stated the process is to verify the order, request the medication from the pharmacy, then complete the medication consent with the resident. She stated that she would speak with the resident to obtain a signature on the consent form, then take the completed form to medical records to be scanned into the EMR. She further stated that she remembered being the nurse that completed the consent form for this resident. The LPN stated that she placed the consent in a basket in the nursing room, she looked in this room and in all the baskets and did not see the resident's Risperdal consent. She reviewed the resident's EMR and stated that she did not see the signed consent. The LPN was not able to present a signed consent or documentation that the resident had been educated and consented to Risperdal prior to administration. Review of the facility's psychoactive medication policy, revised May 2021, revealed that the policy of the facility is to maintain every resident's right to be free from the use of psychoactive medications. The policy further noted that the use of a psychoactive medication must first be explained to the resident, family member, or legal representative. The policy included that a consent is to be obtained either from the resident or responsible party if the resident is unable to give consent.	F 552		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		

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 _____	09/23/2021

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 580	Continued From page 6 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580	**F 580** **Corrective action for residents found to have been affected by this deficiency:** Resident #3's blood sugars have been within ordered perameters for the past four months, and the medical provider has reviewed the accucheck and insulin orders. **Corrective action for residents that may be affected by the deficiency:** Any resident with on accuchecks with ordered perameters may be affected when blood glucose levels are out of range, and the medical provider is to be notified of the change of condition. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were re-inserviced that blood glucose levels either low or high and outside of perameters is considered a change of condition, and the medical provider and resident and/or responsible party is to be notified. Audit tools and audit schedules have been developed. **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:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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 _____	09/23/2021

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 580	Continued From page 7 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and policy reviews, the facility failed to ensure that one resident's (#3) physician was notified of elevated blood sugars. The sample size was 18. The deficient practice could result in physicians not being notified of changes in residents' conditions. Findings include: Resident #3 was admitted to the facility on 8/4/2017 and readmitted on 11/8/2020 with diagnoses that included atherosclerotic heart disease, chronic kidney disease, type 2 diabetes mellitus (DM) with diabetic neuropathy, and hypertension. A review of the care plan initiated on 8/10/2017 revealed the resident was at risk for hyper/hypoglycemia. The goal was that the resident would be free from any signs/symptoms of hyper/hypoglycemia. Interventions included accu check and to observe/document/report to MD (Medical Doctor) signs/symptoms of hypoglycemia and hyperglycemia.	F 580		

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 _____	09/23/2021

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 580	Continued From page 8 Review of the physician's orders revealed an order dated 09/24/2020 for accu check two times a day for DM and to call the MD/NP (Nurse Practitioner) if the blood sugar was <60 or >350. Review of the Medication Administration Report (MAR) for January 2021 revealed the resident's blood sugar was 405 on 1/11/2021 at 8:00 PM and 494 on 1/22/2021 at 8:00 PM. No blood sugar was documented for 1/27/2021 at 8:00 PM and 1/28/2021 at 5:00 AM. The MAR for February 2021 revealed the resident's blood sugar was 368 on 2/06/2021 at 8:00 PM and 354 on 2/26/2021 at 8:00 PM. A review of the MAR for June 2021 revealed the resident's blood sugar was 398 on 6/14/2021 at 8:00 PM. No blood sugar was documented for 6/18/2021 at 5:00 AM. Continued review of the clinical record did not reveal documentation that the MD/NP were notified of the blood sugars that were greater than 350. An interview was conducted with a Licensed Practical Nurse (LPN/staff #11) on 9/23/2021 at 09:10 AM. The LPN stated that when an accu check level is above 350 or below 60, the interventions implemented and physician notification should be documented in the clinical record. She further stated that the expectation is to follow the physician's orders as written. The LPN reviewed resident #3 clinical record and stated that there was no documentation that the physician was notified when the resident's blood sugar was greater than 350. The LPN stated the physician's order had not been followed regarding	F 580		

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 _____	09/23/2021

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 580	Continued From page 9 blood glucose levels and that the risk is that the provider was not aware of the resident's blood sugars that were greater than 350. The LPN also stated that no blood sugar levels documented did not follow the MD order or meet facility expectation. She stated that the risk of blood sugars not being performed as ordered could be hyperglycemia or hypoglycemia. An interview was conducted on 9/23/2021 at 10:18 AM with the Director of Nursing (DON/staff #10) with the Corporate Registered Nurse Clinical Resource in attendance (staff #100). The DON stated that the facility process and expectation is that physician orders and parameters will be followed as written. She stated that the nurses document the blood sugar results on the MAR. She stated that notification to the provider regarding blood sugar levels not meeting parameters would be documented in the nurse progress notes or a daily skilled nurse note. The DON reviewed the clinical record for resident #3 and stated that she did not see documentation that the provider had been notified as ordered when the blood sugar was greater than 300. She stated that the physician order was not followed. Staff #10 stated the risk would be the physician would not be aware of the resident's blood sugar levels that were greater than 350. The DON also stated that blood sugar levels not documented on the MAR did not follow the physician order or meet expectations status. She stated the risk could be hypo or hyper glycemia not being identified. Review of the facility policy titled, Finger Stick Blood Sugars/Hypoglycemia/Hyperglycemia dated 01/2020, revealed all blood sugars out of range will be followed up with physician	F 580		

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 _____	09/23/2021

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 580	Continued From page 10 notification, this will be documented in Point Click Care (PCC). Document all finger blood sugar levels in the EMAR (electronic MAR) in PCC. If documenting follow-up blood sugar levels after interventions, document in PCC or under progress notes. The policy included to follow physician orders. Review of the facility policy titled, Injections, Insulin, revealed that it is the facility policy that insulin injections and blood glucose monitoring will be done following physician's orders.	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews, and facility policy, the facility failed to ensure that two residents (#10 and #3) received blood pressure medications per physician's orders. The sample size was 18 residents. The deficient practice could result in residents not receiving necessary blood pressure medications. Findings include: -Resident #10 was admitted to the facility on March 29, 2021 with diagnoses that included major depressive disorder, chronic pain, type 2 diabetes, and hypertension. Review of the physician's orders revealed an	F 658	**F 658** **Corrective action for residents found to have been affected by this deficiency:** Residents #10 and #3 blood pressures and hypertensive medication orders for the past two months have been reviewed with the attending physician. **Corrective action for residents that may be affected by the deficiency:-** Any resident with blood pressure perameters and PRN blood pressure medication orders may be affected. A full house audit of all residents with these orders, along with their blood pressure for the past two months have been reviewed with the medical provider to ensure PRN antihypertensive medications are still needed. New orders have been obtained where appropriate.	11/12/21

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 _____	09/23/2021

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 658	Continued From page 11 order dated March 29, 2021, for Catapres (a blood pressure medication) 0.1 mg tablet by mouth every 6 hours as needed (prn) for systolic blood pressure greater than 160 millimeters of mercury (mmHg). The quarterly Minimum Data Set (MDS) assessment dated July 6, 2021 revealed that the resident could not complete a Brief Interview for Mental Status (BIMS) due to not being able to be understood. Both the resident's short term and long term memory were assessed to be okay. The resident's hypertension (high blood pressure) care plan, revised August 29, 2021, revealed the resident needed medications to treat hypertension. An intervention included that the medications would be administered as ordered. Review of the resident's vital sign summary and the MARs from June through September 2021 revealed multiple times each month where the resident's systolic blood pressure was greater than 160 mmHg. Further review of the MARs from June through September 2021 revealed that the blood pressure medication was not given when the resident's systolic blood pressure was above 160 mmHg. On September 23, 2021 at 10:38 a.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #8). She stated that if medications are ordered prn, the nurse is expected to check the MAR for the parameters and dosage and compare the vital sign to the parameters listed in the order. If the medication is to be administered per the parameters, she stated that should be documented along with the	F 658	**Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were re-inserviced regarding PRN blood pressure medications and following ordered perameters for administering PRN antihypertensive medications. Audit tools and audit schedules were developed. **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:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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 _____	09/23/2021

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 658	Continued From page 12	F 658		

vital sign or reason for administering the medication. She stated that she also documents this information in a nursing note as well.

An interview was conducted on September 23, 2021 at 10:50 a.m. with a LPN (staff #11). She stated that when giving medication, she looks at the MAR for the resident and reviews the medications. She stated that if a medication has blood pressure parameters, she would check the blood pressure herself and she would document the information in the MAR. She said that if a medication is ordered as prn, the order on the MAR includes a section to enter the vital signs needed to give the medication and this should be filled in anytime the medication is given.

On September 23, 2021 at 11:52 a.m., an interview was conducted with the clinical resource nurse (staff #100), the Director of Nursing (DON/staff #10) and the DON in training (staff #110). Staff #100 stated that when an order is received, if it includes parameters, staff are to follow them. She said that nurses were expected to offer prn medications if needed and if an order is in place. Staff #100 stated that all vitals are documented, especially for PRN medications. Staff #100 stated that vitals can be taken by the nurse or a Certified Nursing Assistant (CNA).

An interview was conducted on September 23, 2021 at 1:01 p.m. with the DON (staff #10). She stated that she had no idea why the blood pressure medication was not given when the resident's systolic blood pressure was above 160 mmHg since this was the what the order said. She said that this does not meet her expectation of medication administration in the facility.

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 _____	09/23/2021

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 658	Continued From page 13	F 658		

-Resident #3 was readmitted to the facility on November 8, 2020 with diagnoses that included atherosclerotic heart disease, chronic kidney disease, type 2 Diabetes Mellitus (DM) with diabetic neuropathy, and hypertension.

A physician's order dated May 25, 2020 was for clonidine 0.1 mg every 8 hours prn for systolic blood pressure over 170 mmHg.

Review of the resident's blood pressure care plan, dated June 21, 2021, revealed the resident had hypertension. Interventions included to take the resident's blood pressure as ordered and to give blood pressure medications as ordered.

Review of the MARs for January through September 2021 revealed that the clonidine was not administered when the resident's systolic blood pressure was over 170 mmHg on several occasions. This occurred every month except for March 2021. It only occurred once in June and August 2021, but occurred multiple times in January, February, April, May, July and September.

Further review of the MAR revealed that on June 18, 2021 the clonidine was administered for a systolic blood pressure of 151 mmHg during the day and then again for a systolic blood pressure of 147 mmHg at night.

An interview was conducted with a LPN (staff #11) on September 23, 2021 at 9:10 a.m., who stated the facility expectation is to follow physician orders as written. She reviewed the physician's order for the clonidine and stated that if the systolic blood pressure is above 170 mmHg,

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 _____	09/23/2021

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 658	Continued From page 14 the medication should be given. She reviewed the MARs for January through September 2021 and stated that the prn clonidine should have been administered on the days that the systolic blood pressure was documented as being over 170 mmHg. She stated that clonidine was administered on June 18, 2021 on both the day and night shifts, but it was not following physician's orders, as the systolic blood pressure was below 170 mmHg on both occasions. She stated that after review of the MARs from January through September 2021, that clonidine had not been administered following physician's orders, and the risk could be worsening of the resident's heart condition. An interview was conducted on September 23, 2021 at 10:18 a.m. with the DON (staff #10), with the Corporate Clinical Resource in attendance (staff #100). The DON stated that it is the facility expectation to administer medications as written in the physician order. She reviewed the medical record and stated that there was a current physician's order for clonidine every 8 hours prn for a systolic blood pressure greater than 170 mmHg. She stated that her expectation is that staff follow the physicians' orders as written. She reviewed the MAR from January to September 2021 and stated that the clonidine had not been given several times when the resident's systolic blood pressure has been greater than 170 mmHg. She further stated that on June 18, 2021, the clonidine had been given for a systolic blood pressure below 170 mmHg, which was not following physician's orders. The DON stated that she will start a process for monitoring medication administration and staff education. Review of the facility's medication administration	F 658		

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 _____	09/23/2021

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 658	Continued From page 15 policy, dated August 2020, revealed that medications must be administered in accordance with the written orders of the attending physician. The policy stated that when prn medications are administered, the nurse must record the justification/reason the medication was given, the date and time the medication was administered, and any results achieved from administering the medication.	F 658	F 677 **Corrective action for residents found to have been affected by this deficiency:** Residents #5 and #7 both frequently refuse showers, and the Director of Nursing and Social Worker have met with each of these residents to ascertain reasons. The medical provider and responsible parties have been notified of the resident's choice to not take showers periodically, and the care plans have been updated. **Corrective action for residents that may be affected by the deficiency:** All residents could be affected. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses and CNAs have been re-inserviced on showers and shower documentation in the medical record, including documenting refusals.. Audit tools and audit processes have been developed. **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:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on an observation, clinical record reviews, facility documentation, interviews, and facility policies, the facility failed to ensure that two residents (#5 and #7) received consistent showers. The sample size was 6 residents. The deficient practice could result in resident grooming and hygiene needs not being met. Findings include: -Resident #5 was admitted to the facility on September 13, 2019, with diagnoses that included anxiety disorder, bipolar disorder, fibromyalgia, rheumatoid arthritis, and muscle weakness. Review of an Activity of Daily Living (ADL) care plan, dated September 14, 2019, revealed the resident had self-care deficits related to diagnoses of fibromyalgia and weakness.	F 677		11/12/21

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 _____	09/23/2021

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 677	Continued From page 16	F 677		

Interventions included the resident required staff participation with personal hygiene, and to provide a sponge bath when a shower cannot be tolerated.

Review of the annual Minimum Data Set (MDS) assessment dated September 21, 2021 revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated that bathing did not occur during the 7-day look-back period of the assessment.

Review of the facility's shower schedule, revealed the resident was to receive a shower every Tuesday and Friday.

Review of bathing documentation revealed that the facility documented bathing in two locations, one was in the Electronic Medical Record (EMR) and the other was on shower sheets. Both were reviewed for July, August, and September 2021 and revealed multiple weeks where the resident either received one shower per week, refused one shower and did not receive another shower in a week, or received no showers per week. This included a stretch of three weeks where the resident received only one shower per week and two consecutive weeks in September that the resident did not receive a shower at all.

During an interview conducted with the resident at 12:07 PM on September 20, 2021, she stated that she used to receive two showers per week, but that lately it had gone to just one per week. She stated receiving a shower depended on who was working and how many staff are available at the time. During the interview, the resident was observed to have hair that was not combed, had

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 _____	09/23/2021

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 677	Continued From page 17 long fingernails on both hands, and was wearing a hospital type gown. The resident stated that she did not like her fingernails long, and that they were not being trimmed frequently. An interview was conducted on September 12, 2021 at 1:06 p.m. with a Licensed Practical Nurse (LPN/staff #11). She stated that residents receive showers two days a week and there is a shower schedule that is followed. She stated that when the Certified Nursing Assistants (CNAs) complete a resident shower, they also complete a shower sheet. She said that when a resident refuses a shower, the CNA documents this on the shower sheet and informs the nurse. She further stated that CNAs will document showers in the EMR. She said this is true when showers are given and when showers are refused. She reviewed the EMR for showers and stated that there was no documentation of the resident receiving a shower after September 10, 2021. She then reviewed additional documentation in the medical record and stated the resident was missing other showers in August and September. She also stated the documentation included that the resident refused some of her showers. The LPN stated that the residents should have their fingernails trimmed at the time of the shower. An interview was conducted on September 21, 2021 at 1:35 p.m. with a CNA (staff #89), who stated the facility expectation is for the residents to receive showers twice a week, or more if there is a need for additional showers. She stated that there is a shower book at the nursing station with the residents' shower days by room number, and is divided between day and night shift. The CNA stated when a resident refuses or is out of the facility, they might not receive a shower twice that	F 677		

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 _____	09/23/2021

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 677	Continued From page 18	F 677		

week, but they try to conduct the shower later in the day or on a different day. She further stated that showers are documented by the CNAs in the medical record, and also on a shower sheet. She stated the process is to give the completed shower sheets to the staffing coordinator (staff #89), who then forwards them to the Director of Nursing (DON). She reviewed the bathing/shower documentation from the EMR and stated there were several days where the resident did not receive a shower.

An interview was conducted on September 21, 2021 at 1:57 p.m. with the staffing coordinator (staff #34), who stated that there is a shower schedule by room number and day, divided into day and night shifts. He stated that the facility expectation is for residents to receive showers twice a week. He stated that he receives the completed shower sheets, which he reviews. He stated that the shower sheets are signed by the nurses after the shower. He reviewed the shower sheets for the resident and stated the most current shower sheet for the resident was from September 10, 2021. He then reviewed the shower sheets for August 2021 and stated he could only find 5 shower sheets for that month. He reviewed the July 2021 shower sheets and stated he had completed forms for 4 days of that month. He further stated that this does not follow facility expectations.

An interview was conducted on September 21, 2021 at 2:38 p.m. with the DON (staff #10), who stated that the facility expectation is for residents to receive two showers a week, following the shower schedule. She further stated that the showers would be documented by CNAs on the shower sheets, and in the EMR medical record.

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 _____	09/23/2021

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 677	Continued From page 19	F 677		

She reviewed the EMR and stated that no showers were given or refused from September 12 to 24, 2021, and this is not following facility policy.

An interview was conducted on September 22, 2021 at 9:58 a.m. with the Corporate Clinical Resource (staff #100) who stated that she further reviewed the resident's medical records, shower sheets and found no other documentation regarding showers. She further stated that they had started education last night and today regarding shower documentation.

-Resident #7 was admitted to the facility on September 14, 2018 with diagnoses that included epilepsy, muscle weakness, major depressive disorder, and other secondary gout to the left ankle and foot.

Review of the resident's ADL care plan dated September 14, 2018, revealed the resident had an ADL self-care performance deficit related to decreased active functional mobility, muscle weakness, difficulty walking, and risk of incontinent episodes. The resident required limited to extensive assistance of one to two staff for ADLs. The goal was for the resident to safely perform ADLs with assistance from 1 to 2 staff through the review date. Interventions included to explain all procedures/tasks to the resident before starting and praise all efforts of self-care.

The quarterly MDS assessment dated May 24, 2021, revealed the resident had a BIMS score of 14, which indicated no cognitive impairment. The MDS identified that the resident required one-person assistance with bed mobility and

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 _____	09/23/2021

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 677	Continued From page 20	F 677		

transfer, and required set up assistance with hygiene. The MDS also indicated that the resident required one-person assistance with bathing.

Review of the facility's shower schedule, revised July 2, 2021, revealed the resident was to receive showers on Tuesdays and Fridays.

Review of bathing documentation revealed that the facility documented bathing in two locations, one was in the Electronic Medical Record (EMR) and the other was on shower sheets. Both were reviewed for July, August, and September 2021 and revealed multiple weeks where the resident did not receive two showers per week including a stretch in August where the resident did not receive a shower at all from August 10 through 31.

Review of the nursing notes from July 1 through September 22, 2021 revealed no evidence that the resident was provided a shower or the resident refused a shower on the dates that did not have a shower sheet or bathing documentation in the EMR. There were no notes to show that the resident received any additional showers.

An interview with the resident was conducted on September 20, 2021 at 12:42 p.m. He stated that he does not receive showers regularly. He stated he thinks he does not receive his showers as scheduled because there are not enough staff to provide the showers.

An interview was conducted with a CNA (staff #82) on September 21, 2021 at 1:58 p.m. She stated that showers are provided according to the shower schedule. She stated the facility has 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 _____	09/23/2021

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 677	Continued From page 21	F 677		

shower book by the nursing station which includes the shower schedule as well as shower sheets. She said the showers are to be documented on the shower sheet as well as in the EMR. She stated if a resident refuses a shower, she will try to reschedule the shower but she still has to fill in the shower sheet and the resident has to sign the shower sheet. She stated she had not had issues with residents not receiving showers, but said sometimes the residents tell her that they have not received showers for many days.

An interview was conducted with a CNA (staff #89) on September 21, 2021 at 2:28 p.m. She stated that showers are done twice per week and are document both in the EMR and on a shower sheet that is signed by the CNA and the nurse. She said that after the sheet is signed, it goes to the staffing coordinator (staff #34) and then to the DON (staff #10).

An interview was conducted with a CNA (staff #33) on September 22, 2021 at 12:57 p.m. She stated that the resident needs set-up help for showers but is able to shower himself. She said that the resident does not usually refuse showers but that she has been having issues charting showers in the EMR lately because it was not coming up easily.

An interview was conducted with a LPN (staff #85) on September 22, 2021 at 1:34 p.m. She stated that showers are provided by the CNA and the CNA fills out the shower sheet. She stated the CNA then turns in the shower sheets to the nurse for review and both of them sign the sheet. She stated the shower sheet is then given to the staffing coordinator or the DON. She stated 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 _____	09/23/2021

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 677	Continued From page 22 this resident refuses showers sometimes and if a resident refuses a shower, the shower sheet is signed by the resident. She stated shower refusals are also documented in nursing notes in the resident's clinical record. An interview was conducted with the DON (staff #10) on September 22, 2021 at 2:08 p.m. She stated the facility has started in-servicing the staff to document showers in one place or location. She stated after a shower sheet is filled out, the staff hand the shower sheets to the staffing coordinator (staff #34) who reviews them and gives them to her. She said she also reviews them to ensure they are filled out correctly and completely. She stated that they are not reviewing them to ensure the showers are being provided as scheduled. Review of the facility's ADL policy, revised July 2020, revealed that bathing will be offered at least twice per week and as needed per resident request. The policy also noted that ADL care provided will be documented accordingly. The facility's shower and bed bath policy, revised May 2021, revealed that showers and bed baths will be provided to residents in accordance with the resident's shower schedule. If a resident is unable to be showered on their scheduled day due to room changes or appointments, staff will attempt to reschedule and the shower or bed bath will be documented accordingly.	F 677		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility	F 732		

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 _____	09/23/2021

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 732	Continued From page 23 must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the Daily Nurse Staffing Information, staff interview, and policy review, the facility failed to ensure that daily posted nurse	F 732	**F 732** **Corrective action for residents found to have been affected by this deficiency:** Not applicable **Corrective action for residents that may be affected by the deficiency:** Any resident and/or responsible party may be affected. **Measures that will be put into place to ensure that this deficiency does not recur:** Staffing Coordinator, DNS, HR, and ED have been re-inserviced on the Daily Staffing Posting regulations, and procedures. Audit tools and processes have been developed. **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:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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 _____	09/23/2021

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 732	Continued From page 24 staffing information included the actual hours worked by licensed and unlicensed nursing staff. The deficient practice resulted in information not being readily available to residents and visitors. Findings include: Review of the Daily Nurse Staffing Information for the months of July 2021 and August 2021, revealed there was a place to document actual hours worked, however, no information was documented for the actual hours worked by licensed and unlicensed staff for July 2, 3, 4, 8, 9, 10, 11, 15, 20, and 21, 2021, and August 6, 20, 25, and 26, 2021. In an interview conducted with the staffing coordinator (staff #34) with the Director of Nursing (staff #10) present on September 23, 2021 at 12:52 p.m., he stated he had only been in this role for a brief time. Staff #34 also stated that he wanted to know exactly what needed to be filled out on the Daily Nurse Staffing Information sheets so that they would be correct. Review of the facility Staff Posting Policy dated October 2018, revealed it is the policy of this facility to post nursing staff daily. The policy also revealed the posting will be placed in a visible area for all residents and resident families. The procedure in the policy stated to place out daily nursing schedule and place out staffing calculator with hours PPD (per patient day).	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		

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 _____	09/23/2021

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 757	Continued From page 25 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews, and facility policy, the facility failed to ensure that one resident (#10) did not receive an unnecessary pain medication. The sample size was 18 residents. The deficient practice could result in residents receiving unnecessary medications. Findings include: Resident #10 was admitted to the facility on March 29, 2021 with diagnoses that included major depressive disorder, chronic pain, type 2 diabetes, and hypertension. Review of the physician's orders revealed an order dated March 29, 2021 for oxycodone/acetaminophen (pain medication that	F 757	F 757 **Corrective action for residents found to have been affected by this deficiency:** Resident #10 PRN pain medication orders, along with the resident's pain levels daily, have been reviewed with the medical provider. **Corrective action for residents that may be affected by the deficiency:** Any resident with multiple PRN pain medications could be affected. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses have been re-inserviced regarding PRN pain medications and PRN pain scales. Audit tools and audit processes have been developed. **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:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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 _____	09/23/2021

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 757	Continued From page 26 includes an opioid) tablet 10/325 milligrams (mg) 1 tablet by mouth every 4 hours as needed (prn) for pain of 4 to 10 on the pain scale. Review of the resident's pain care plan, dated March 30, 2021, revealed the resident had acute and chronic pain. An intervention included to administer pain medications according to the pain scale. The care plan was revised on August 29 to include that the resident was prescribed an opioid pain medication. The quarterly Minimum Data Set (MDS) assessment dated July 6, 2021 revealed that the resident could not complete a Brief Interview for Mental Status (BIMS) due to not being able to be understood. Both the resident's short term and long term memory were assessed to be okay. The assessment included that the resident received opioids daily during the 7-day lookback period. Review of the resident's Medication Administration Records (MAR) from June through September 2021 revealed that the medication was administered outside of the physician ordered parameters on several occasions when it was administered for pain levels below 4 out of 10. This included several times when the medication was given for a pain level of 0 out of 10. Review of the nursing notes revealed no indication as to why the medication was given outside of the ordered parameters. An interview was conducted on September 23, 2021 at 10:50 a.m. with a Licensed Practical Nurse (LPN/staff #11). She stated that when	F 757		

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 _____	09/23/2021

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 757	Continued From page 27 administering a medication, she reviews the order and the MAR. She said that if the order includes parameters for administration, such as a specific pain level, she would check the pain scale herself and then document this information in the MAR. She said that the pain level would determine if the pain medication is given. She said she would follow the parameters on the order to ensure she gives the right medication. She said that if a pain medication is given outside of the ordered parameter, it may be because the nurse who administered the medication did not fully know what they were doing because the order should be specific. She said that if this occurs, it could cause unwanted and unexpected side effects due to the unnecessary administration of the pain medication. She reviewed the resident's September 2021 MAR and said that there were several instances where the prn pain medication was given outside of the ordered parameters. She said that this did not make any sense and she was not sure why this happened. She said that this was especially true when the pain medication was given for a pain level of 0 since this would mean that the resident did not have pain and therefore would not need prn pain medication. On September 23, 2021 at 11:52 a.m., an interview was conducted with the clinical resource nurse (staff #100), the Director of Nursing (DON/staff #10) and the DON in training (staff #110). Staff #100 stated that when an order is received, if it includes parameters, staff are to follow them. She said that nurses were expected to offer prn medications if needed and if an order is in place. She further stated that if a prn medication is needed, the nurse that administered the	F 757		

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 _____	09/23/2021

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 757	Continued From page 28 medication was expected to ensure the pain level is correctly documented in the resident's MAR. The DON stated that the pain level documented on the MAR is the original pain level that the resident stated and the follow up pain scale number should be documented in the nursing notes. The 3 staff members reviewed the September MAR and agreed that there were at least 2 instances that the prn pain medication was given outside the parameters. Review of the facility's medication administration policy, dated August 2020, revealed that medications must be administered in accordance with the written orders of the attending physician. The policy stated that when prn medications are administered, the nurse must record the justification/ reason the medication was given, the date and time the medication was administered, and any results achieved from administering the medication.	F 757		

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

October 7, 2021

Receipt Of This Notice Is Presumed To Be 10/07/2021
Important Notice - Please Read Carefully

Joaquin Martinez, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr Martinez:

On September 24, 2021, a **Life Safety Code** survey, #A3PR21, 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. Although the survey found that your facility was in substantial compliance with the participation requirements, some deficiencies exist.

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 **October 17, 2021**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **October 7, 2021**, may result in the imposition of remedies.

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.

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

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 **December 12, 2021.**

If, upon the 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 continuing 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, per day, per tag, effective September 24, 2021

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.

Mandatory Remedies

Your current period of noncompliance began on September 24, 2021. 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 April 6, 2022.

Informal Dispute Resolution

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

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.

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **10/17/2021**, 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,

Diane Eckles

Diane Eckles
Bureau Chief

DE\mm

Attachments

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.41(a) Nursing Home The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association This is a recertification survey for Medicare under LSC 2012, Chapter 19, Existing. The entire facility, was surveyed on September 28, 2021. The facility meets the standards, based on acceptance of a plan of correction.	K 000	ARIZONA DEPARTMENT OF HEALTH DIVISION OF PUBLIC HEALTH LICENSING OCT 15 2021 LONG TERM CARE 150 N. 18TH AVE # 440 PHOENIX, AZ 85007	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.	K 923	**K923** **Corrective action for residents found to have been affected by this deficiency:** Observations made while on tour on September 28, 2021, revealed (1) one unsecured medical gas oxygen cylinders E-type located in the gas oxygen storage room in facility was observed not to be secured in a rack or stand. E-tank placed in rack, issue resolved. **Corrective action for residents that may be affected by this deficiency:** All residents have the potential to be affected by this deficiency.	11/12/21

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 10/15/2021

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 rs following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 1 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to secure (1) one E-type medical gas oxygen cylinders in a stand or cart. Failing to secure compressed medical gas cylinders could cause harm to the residents and staff. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.2.4 "Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities." NFPA 99 2012 Edition Chapter 11 Section 11.6.2.3 (11) Free standing cylinders shall be properly chained or supported in a proper cylinder stand or cart." Findings include: Observations made while on tour on September 28, 2021, revealed (1) one unsecured medical gas oxygen cylinders E-type located in the oxygen storage room in facility was observed not to be secured in a rack or stand.	K 923	K923 Continued Measures that will be put into place to ensure that this deficiency does not reoccur: In services shall be conducted with all staff on proper oxygen handling. Daily inspections of oxygen storage to be conducted to obtain compliance. Weekly inspections of oxygen storage room to be conducted to maintain compliance. Weekly inspections to be put on Tels to maintain compliance. Administrator or designee will ensure compliance. Measures that will be implemented to monitor the continued effectiveness on the corrective action taken to ensure that this deficiency has been corrected and will not recur: The QA committee will review the findings during scheduled QA meetings to ensure that the protocols set forth with these corrective measures are followed.	11/12/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 2 During the exit conference on September 28, 2021, the above findings were again acknowledged by the management staff.	K 923		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 7, 2021

Receipt of This Notice is Presumed To Be 10/07/2021
Important Notice - Please Read

Joaquin Martinez, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr. Martinez:

On **September 24, 2021**, a recertification survey , #A3PR21, was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal/State participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaint investigations may have also been conducted.

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

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

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\mm

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 _____	09/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 42CFR 483.73, Long Term Care Facilities The facility must meet all applicable Federal, State and local emergency preparedness requirements as outlined in the Medicare and Medicaid Programs: Emergency Preparedness Requirements of Medicare and Medicaid Participating Providers and Suppliers Final Rule (81 FR 63860) September 16, 2016. No apparent deficiences noted at the time of the survey.	E 000		

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

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey:

From: F1 *(mm/dd/yyyy)*: 9/20/2021

To: F2 *(mm/dd/yyyy)*: 9/23/2021

Extended Survey:

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

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

Name of Facility: Granite Creek Health and Rehabilitation Center

Provider Number: 035131

Fiscal Year Ending: F5 *(mm/dd/yyyy)*: 12/31/2021

Street Address: 1045 Scott Drive

City: Prescott

County: Yavapai

State: AZ

Zip Code: 86301

Telephone Number: F6: (928) 778-9603

State/County Code: F7:

State/Region Code: F8:

F9: 03

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

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

If yes, indicate Hospital Provider Number: F11

Ownership: F12: 03

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

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

Name of Multi-Facility Organization: F14: Pandera Healthcare, LLC

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

F15 AIDS: 0	F16 Alzheimer's Disease: 0	F17 Dialysis: 0
F18 Disabled Children/Young Adults: 0	F19 Head Trauma: 0	F20 Hospice: 0
F21 Huntington's Disease: 0	F22 Ventilator/Respiratory Care: 0	F23 Other Specialized Rehabilitation: 0

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

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

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

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

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

Waiver of seven day RN requirement:		**Waiver of 24 hr licensed nursing requirement:**	
Date: F28 *(mm/dd/yyyy)*	Hours waived per week: F29	Date: F30 *(mm/dd/yyyy)*	Hours waived per week: F31
N/A	N/A	N/A	N/A

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

Name of Person Completing Form	Time
Joaquin Martinez	5:00 pm
Signature	**Date**
[signature]	9/20/2021

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035131	12 F75	41 F76	19 F77	72 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 0	F80 57	F81 15
Dressing	F82 6	F83 50	F84 16
Transferring	F85 6	F86 62	F87 4
Toilet Use	F88 0	F89 68	F90 4
Eating	F91 1	F92 68	F93 3

A. Bowel/Bladder Status

F94 4 With indwelling or external catheter

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

F96 43 Occasionally or frequently incontinent of bladder

F97 33 Occasionally or frequently incontinent of bowel

F98 43 On urinary toileting program

F99 38 On bowel toileting program

B. Mobility

F100 0 Bedfast all or most of time

F101 51 In a chair all or most of time

F102 4 Independently ambulatory

F103 17 Ambulation with assistance or assistive device

F104 0 Physically restrained

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

F106 6 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 6 ?

C. Mental Status

F108-114 – indicate the number of residents with:

F108 0 Intellectual and/or developmental disability

F109 29 Documented signs and symptoms of depression

F110 9 Documented psychiatric diagnosis (exclude dementias and depression)

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

F112 0 Behavioral healthcare needs

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

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

D. Skin Integrity

F115-118 – indicate the number of residents with:

F115 6 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 6 ?

F117 72 Receiving preventive skin care

F118 1 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 11 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 1 Dialysis

F123 3 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 36 Respiratory treatment

F125 0 Tracheostomy care

F126 0 Ostomy care

F127 0 Suctioning

F128 15 Injections (exclude vitamin B12 injections)

F129 1 Tube feedings

F130 15 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 39 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 1 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 41 Any psychoactive medication

F134 9 Antipsychotic medications

F135 12 Antianxiety medications

F136 29 Antidepressant medications

F137 1 Hypnotic medications

F138 9 Antibiotics

F139 43 On pain management program

G. Other

F140 2 With unplanned significant weight loss/gain

F141 0 Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 0 Who use non-oral communication devices

F143 72 With advance directives

F144 33 Received influenza immunization

F145 21 Received pneumococcal vaccine

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

Signature of Person Completing the Form	Title	Date
[signature] RN	Director of Nurses	09/21/21

TO BE COMPLETED BY SURVEY TEAM

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

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

F148 Medication error rate 0 %

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

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

Provider Beds
Total: 128
Certified: 128

Provider Category: SNF/NF (DUAL)

Type Action: RECERTIFICATION
Type Ownership: FOR PROFIT - CORPORATION

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

Program Requirements

Current Survey/Revisit Dates - 07/03/2019

Prior 3 Survey 11/2015	S/S Code	Prior 2 Survey 01/2017	S/S Code	Prior 1 Survey 03/2018	S/S Code	Current Survey 05/23/2019	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	-	-	- -	-	-	REQ	F0157-NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
-	-	-	-	-	-	- -	-	-	REQ	F0160-CONVEYANCE OF PERSONAL FUNDS UPON DEATH
-	-	-	-	-	-	- -	-	-	REQ	F0204-PREPARATION FOR SAFE/ORDERLY
-	-	-	-	-	-	- -	-	-	REQ	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
-	-	-	-	-	-	- -	-	-	REQ	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
X	D	-	-	-	-	- -	-	-	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	-	-	-	-	- -	-	-	REQ	F0248-ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES
-	-	-	-	-	-	- -	-	-	REQ	F0272-COMPREHENSIVE ASSESSMENTS
-	-	-	-	-	-	- -	-	-	REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
-	-	-	-	-	-	- -	-	-	REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
-	-	-	-	-	-	- -	-	-	REQ	F0280-RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
-	-	-	-	-	-	- -	-	-	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
-	-	-	-	-	-	- -	-	-	REQ	F0282-SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
X	D	-	-	-	-	- -	-	-	REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
-	-	-	-	-	-	- -	-	-	REQ	F0312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
-	-	-	-	-	-	- -	-	-	REQ	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
-	-	-	-	-	-	- -	-	-	REQ	F0325-MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE
-	-	-	-	-	-	- -	-	-	REQ	F0327-SUFFICIENT FLUID TO MAINTAIN HYDRATION
-	-	-	-	-	-	- -	-	-	REQ	F0328-TREATMENT/CARE FOR SPECIAL NEEDS
-	-	-	-	-	-	- -	-	-	REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
-	-	-	-	-	-	- -	-	-	REQ	F0333-RESIDENTS FREE OF SIGNIFICANT MED ERRORS
-	-	-	-	-	-	- -	-	-	REQ	F0334-INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS
X	D	X	E	-	-	- -	-	-	REQ	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
-	-	-	-	-	-	- -	-	-	REQ	F0411-ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
-	-	-	-	-	-	- -	-	-	REQ	F0428-DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON
-	-	-	-	-	-	- -	-	-	REQ	F0431-DRUG RECORDS, LABEL/STORE DRUGS &

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

Prior 3 Survey 11/2015	S/S Code	Prior 2 Survey 01/2017	S/S Code	Prior 1 Survey 03/2018	S/S Code	Current Survey 05/23/2019	S/S Code	Plan/Date of Correction		Requirement
X	D	X	D	-	-	- -	-	-	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
-	-	-	-	-	-	- -	-	-	REQ	F0500-OUTSIDE PROFESSIONAL RESOURCES-
-	-	-	-	-	-	- -	-	-	REQ	F0502-ADMINISTRATION
-	-	-	-	-	-	- -	-	-	REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
-	-	-	-	-	-	X C	D	07/01/2019	REQ	F0684-Quality of Care
-	-	-	-	-	-	X C	D	07/01/2019	REQ	F0686-Treatment/Svcs to Prevent/Heal Pressure Ulcer
-	-	-	-	-	-	X C	E	07/01/2019	REQ	F0696-Prostheses

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 11/2015	S/S Code	2012 HC Prior 2 Survey 01/2017	S/S Code	2012 HC Prior 1 Survey 03/2018	S/S Code	2012 HC Current Survey 05/23/2019	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	-	-	-	-	- -	-	-	STD	K0232-Aisle, Corridor, or Ramp Width
-	-	-	-	-	-	- -	-	-	STD	K0281-Illumination of Means of Egress
-	-	-	-	-	-	- -	-	-	STD	K0321-Hazardous Areas - Enclosure
-	-	-	-	-	-	- -	-	-	STD	K0353-Sprinkler System - Maintenance and Testing
-	-	-	-	-	-	- -	-	-	STD	K0363-Corridor - Doors
-	-	-	-	-	-	- -	-	-	STD	K0511-Utilities - Gas and Electric
-	-	-	-	-	-	- -	-	-	STD	K0923-Gas Equipment - Cylinder and Container Storag

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

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	3	0	2	4
Health Total	3	0	2	4
Life Safety Code	0	0	0	0
Life Safety Code + Health	3	0	2	4

Complaint Survey Information

Survey Date	Status
07/02/2020	Substantiated
05/23/2019	Unsubstantiated
03/15/2018	Unsubstantiated
01/26/2017	Unsubstantiated

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

LTC Resident Census

Resident Census on 05/23/2019
Total: 89
Medicare: 10
Medicaid: 55
Other: 24

Total Certified Beds: 128

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

Supplemental

F-732 **Posted Nurse Staffing Information**

§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

(iv) Resident census.

§483.35(g)(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

INTENT **§483.35(g)**

To make staffing information readily available in a readable format to residents and visitors at any given time.

GUIDANCE **§483.35(g)**

The facility's "document" may be a form or spreadsheet, as long as all the required information is displayed clearly and in a visible place. The information should be displayed in a prominent place accessible to residents

and visitors and presented in a clear and readable format. This information posted must be up-to-date and current.

The facility is required to list the total number of staff and the actual hours worked by the staff to meet this regulatory requirement. The information should reflect staff absences on that shift due to call-outs and illness.

Staffing must include all nursing staff who are paid by the facility (including contract staff). The nursing home would not include in the posting staff paid for through other sources; examples include hospice staff covered by the hospice benefit, or individuals hired by families to provide companionship or assistance to a specific resident.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F732, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- *Ensure staffing information was posted in a prominent place readily accessible to residents and visitors; or*
- *Ensure staffing information was accurate and current; or*
- *Ensure staffing information was complete and was not missing information (e.g.. specific units were not reflected on the posting); or*
- *Maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.*

GRANITE CREEK HEALTH AND REHABILITATION

Daily Staffing Posting Accuracy

Date	Staffing Posting Present with types of staff and projected hours Yes or No	Daily Staffing Posting updated with the actual hours worked by type of staff Yes or No	If No, Action Taken
10-4-21	Yes	Yes	
10-5-21	Yes	Yes	
10-6-21	Yes	Yes	
10-7-21	Yes	Yes	
10-8-21	Yes	Yes	
10-9-21	Yes	Yes	
10-10-21	Yes	Yes	
10-11-21	Yes.	Yes	

Granite Creek Health And Rehab
Policy / Procedure - Nursing Clinical

Section: **Licensed Nurse Procedures**

Subject: **Oxygen Handling and Storage**

POLICY:

It is the policy of this facility to provide proper use and handling of oxygen tanks in facility.

PROCEDURES:

1. STORAGE
   Storage of oxygen tanks must be accompanied in a safe manner. All tanks must be secured to a wall within a chain or heavy cable. Safety cups will be installed on all tanks not in use, whether full or empty. Full tanks will be separated from empty tanks and identified as such.

2. HANDLING AND TRANSPORTATION
   No tank will be left unattended on a transport dolly. Transport dollies will not be used as a support when oxygen is being administered to a resident.

3. TRANSPORTING
   Under no circumstances will oxygen tanks be transported with the safety cup removed and gauges installed.

ESSENTIAL POINTS

Under no circumstances will a petroleum-base lubricant (WD 40, 3-in-1 Oil, etc.) be used around oxygen equipment. All wrenches will be kept clean and free of oil. Any petroleum-base substance coming in contact with oxygen could cause an instantaneous explosion.

GRANITE CREEK HEALTH AND REHABILITATION

SAFETY-OXYGEN STORAGE AUDIT

Date Checked	Oxygen Room-All tanks secured Yes or No	Oxygen tanks in use in rooms secured- Yes or No	Action taken, if needed
9-28-21	Yes	Yes	
9-28-21	Yes	Yes	
9-29-21	Yes	Yes	
9-29-21	Yes	Yes	
9-30-21	Yes	Yes	
10-1-21	Yes	Yes	
10-1-21	Yes	Yes	
10-2-21	Yes	Yes	
10-4-21	Yes	Yes	
10-4-21	Yes	Yes	
10-5-21	Yes	Yes	
10-5-21	Yes	Yes	
10-6-21	Yes	Yes	
10-6-21	Yes	Yes	
10-7-21	Yes	Yes	
10-7-21	Yes	Yes	
10-8-21	Yes	Yes	
10-11-21	Yes	Yes	
10-11-21	Yes	Yes	

GRANITE CREEK HEALTH AND REHABILITATION

SAFETY-OXYGEN STORAGE AUDIT

Date Checked	Oxygen Room-All tanks secured Yes or No	Oxygen tanks in use in rooms secured- Yes or No	Action taken, if needed
10-12-21	Yes	Yes	
10-12-21	Yes	Yes	
10-13-21	Yes	Yes	
10-14-21	Yes	Yes	
10-15-21	Yes	Yes	