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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QCE0

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 **01/26/2017** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room
* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Granite Creek Health & Rehabilitation Center is out of compliance with federal regulations based on annual survey 01/26/2017. Granite Creek Health & Rehabilitation Center is back in compliance with federal regulations based on an acceptable plan of correction and the revisit survey completed on 03/06/2017 State Agency recommended recertification.

17. SURVEYOR SIGNATURE Diane Eckles Date: 03/15/2017 (L19)
Desiree Fasimonsko

18. STATE SURVEY AGENCY APPROVAL Date: 03/15/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
10301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

March 15, 2017

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

Re: Provider Number 035131

Dear Mr. Curran:

Your facility has just received its recertification survey for the Federal Title XVIII (Medicare) and Federal Title XIX (Medicaid/AHCCCS) program.

The facility's Medicare/Medicaid provider Agreement will be continuous, unless you are contacted by our Office or the Centers for Medicare/Medicaid Services to the contrary.

You should keep a copy of this notice with your signed provider agreement.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE/bh

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

March 15, 2017

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

Dear Mr. Curran:

Enclosed is the **Post-Certification Revisit Report** forms which indicates that the following deficiencies have been corrected on March 6, 2017. A copy will be filed in your public file.

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

Sincerely,

B Hernandez

Belinda Hernandez
CSR4/Licensing Certification Specialist

\bh

Enclosure

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	3/6/2017 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 F0371 Reg. # 483.60(i)(1)-(3) LSC	Correction Completed 03/05/2017	ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/05/2017	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) DA	DATE 3/6/17	SIGNATURE OF SURVEYOR Dal Colon	DATE 3/6/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/26/2017	☐ 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

March 15, 2017

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

Dear Mr. Curran:

On January 26, 2017, a survey was conducted at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and presume that you have achieved substantial compliance. Based on this presumed compliance, we are not forwarding to the Centers for Medicare/Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency our recommendation that the remedies we indicated in our letter to you of 02/072017 be imposed at this time.

We may be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained. We will certify your facility in compliance if we find that your facility is in substantial compliance at the time of the revisit. If we find that your facility has failed to achieve or maintain substantial compliance, the following remedies (or revised, if appropriate) will be imposed:

Recommendation to CMS for Civil money penalty, effective January 26, 2017

A civil money penalty, if imposed, will continue until you have achieved substantial compliance or your provider agreement is terminated.

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

Sincerely,

B Hernandez

Belinda Hernandez
CSR4/Licensing Certification Specialist

/bh

cc: State Ombudsman (with POC)

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Receipt of Notice Presumed 02/07/2017 via email

February 7, 2017

Chandler Monks, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Monks:

On **January 26, 2017**, a Medicare recertification survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaints investigations may have also been conducted.

This survey found the most serious deficiency(ies) in your facility to be 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).

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 **February 17, 2017**. You must include all pages of the Statement of Deficiencies when submitting your PoC.

Failure to submit an acceptable PoC by **February 17, 2017** may result in the imposition of remedies. **Plans of correction sent by fax will not be accepted.**

Your PoC must contain the following:

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

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

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

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

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

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 **03/12/2017.**

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, per day/Instance, effective January 26, 2017

Mandatory Remedies

Your current period of noncompliance began on January 26, 2017. 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 09/12/2017.

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

06/12/20017. 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.

Appeal Rights

If you disagree with the determination of noncompliance (and/or substandard quality of care, if applicable), you or your legal representative may request a hearing before an administrative law judge of the 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 written request for hearing must be filed no later than (60 days from the date of receipt of this letter). Such written request should be made directly to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for 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 be represented at a hearing by counsel at your own expense.
Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a copy of your request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 1h Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided 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 or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

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 Joel Bunis, 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: Effective July 1, 2007, facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **February 17, 2017**, licensure and/or recertification may be denied. **Plans of correction sent by fax will not be accepted.** If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:bh

Attachments

2/17/17 Appv 3/5/17 AOC

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

PRINTED: 02/07/2017
FORM APPROVED
OMB NO. 0938-0391

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 _____	01/26/2017

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

RECEIVED
Arizona Department of Health
Division of Public Health
Licensing Services
FEB 16 2017
Reception Desk
150 N. 18th Ave #400
Phoenix, AZ 85007

F 000 INITIAL COMMENTS

The annual recertification survey was conducted on January 23, through 26, 2017, in conjunction with the following Complaints: #'s AZ00134209 AZ00139445 and AZ00134372. The following deficiencies were cited:

F 371 SS=E 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and review of policy and procedures, the facility failed to ensure that stored, ready to use pans and

F 000

F 371

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.

(Initials)

F 371

Corrective action for residents found to have been affected by this deficiency:

All residents were potentially affected. Wet pans and those pans and/or tulip cups that had food particles were removed and re-washed, and allowed to air dry on dish racks. 3-5-17

Corrective action for residents that may be affected by the deficiency:

All residents were potentially affected. Wet pans and those pans and tulip cups that had food particles were removed and re-washed and allowed to air dry on dish racks. All other pans and dishes were re-checked to assure that none were stored wet or had food particles.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2/15/17

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 _____	01/26/2017

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 371	Continued From page 1 dishes were dry and free of food particles. Findings include: Observations were conducted in the kitchen at 1:50 p.m. on January 25, 2017. There were three, two inch full size steam table pans which were stacked and ready to use. The top two pans had water that dripped when tipped, on the interior surfaces and both had food particles adhering to the interior surfaces. Also, there were two of four stacked, ready to use four inch quarter steam table pans, which had particles adhering to the interior surfaces. One of the pans had water adhering to the interior surface and dripped when tipped. Additional observations in the kitchen revealed there was a large covered container, which contained plastic tulip cups that were stored ready to use. One of the tulip cups had a purple, dry substance in the interior surface of the cup. In a second container, there was a stack of six plastic tulip bowls, which had approximately 1/4 to 1/2 teaspoon of water in each bowl. During an interview at the time of the observations, a dietary aid (staff #14) stated the tulip bowls had not been used and were washed today. She also stated that she should have checked the dishes and pans after they were washed to ensure they were clean and free of food particles. During an interview conducted at 2:29 p.m. on January 25, 2017, the dietary manager (staff #9) stated the dishes are suppose to be air dried, before being stacked on the rack where the ready to be used pans are stored. He also stated that	F 371	**Measures that will be put into place to ensure that this deficiency does not recur:** Dietary staff were re-inserviced on washing dishes and pans, and air drying dishes and pans on drying racks. Staff were re-inserviced to double check for any food particles adhering to the dishes and/or pans following wash, and to re-wash immediately, and then air dry. **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 observation audits by the Dietary Manager will be conducted weekly, for clean and air drying pans and dishes. Findings and analysis will be reported to the QAA Committee monthly.	3-5-2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 2 the tulip bowls were washed the day before (January 24) and that allowing the wet dishes to sit with pooled water could lead to the growth of bacteria and mold. A review of the Dry Storage Dishes and Utensils policy and procedure revealed, "Dishes must be stored to promote air drying i.e. use dish racks or trays with plastic mesh that allow air to circulate and air dry dishes." A review of the Pots and Pans - Hot water policy and procedure revealed "When items are dry, store in proper storage area."	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the	F 441	**F 441** **Corrective action for residents found to have been affected by this deficiency:** Licensed nurse staff #87 was immediately re-inserviced regarding medication administration techniques, including not touching medication with bare hands, for this affected resident or any other resident. **Corrective action for residents that may be affected by the deficiency:** Any resident needing medications administered in applesauce by licensed nurse staff #87 could be potentially affected. Licensed nurse staff #87 was immediately re-inserviced regarding medication administration techniques, including not touching medication with bare hands at any time. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were re-inserviced regarding medication administration techniques policy and procedures, including not touching medications with bare hands, on 2/8/2017 and on 2/11/2017. Medication pass observations were again done on licensed nurses.	3-5-2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 441	Continued From page 3 facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their	F 441	**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 medication pass observations will be done weekly, and findings reported to the QAA Committee monthly.	3-5-2017

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 _____	01/26/2017

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 441	Continued From page 4 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and policy review, the facility failed to ensure infection control procedures were followed during medication administration. Findings include: During a resident interview conducted on January 24, 2017, a LPN (Licensed Practical Nurse/staff #87) was observed to enter the resident's room and prepare to administer medications to the resident. Staff #87 had a plastic medicine cup with applesauce in it, and a paper cup with several medications inside. Staff #87 placed applesauce on a teaspoon and then, with her bare fingers, she picked up two medications from the paper medication cup and placed them on the teaspoon of applesauce. Staff #87 then repeated this same process two more times. An interview was conducted on January 25, 2017 at 8:15 a.m., with the Director of Nursing (staff #129). Staff #129 stated that the LPN should never have touched the resident's pills with her bare hands, because hands are never clean. She stated the LPN should have used the spoon to scoop up the pills and then put them into the applesauce. A facility policy titled, General Dose Preparation and Medication Administration included the following: 3.4 Facility staff should not touch the medication when opening a bottle or unit dose package.	F 441		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

Receipt of Notice Presumed 02/07/2017 via email

February 7, 2017

Chandler Monks, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr Monks:

Enclosed is the Life Safety Code deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. These forms will become a part of our public file; please sign then send back the first page with orginal signatures and retain a copy for your files.

If I 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\bh

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/27/2017

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 42CFR 483.70(a) Nursing Homes 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 of a Skilled Nursing Facility. The entire facility was surveyed. The facility meets the standards, based upon compliance with all provisions of the standards. There were no apparent deficiencies noted at the time of the survey.	K 000	RECEIVED Arizona Department of Health Division of Public Health Licensing Services FEB 16 2017 Reception Desk 150 N. 18th Ave #400 Phoenix, AZ 85007	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2/15/17

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

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 01 23 17 To: F2 01 26 17
MM DD YY MM DD YY

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

Name of Facility	Provider Number	Fiscal Year Ending: F5
Watson Woods Healthcare, Inc dba Granite Creek Health Cente	035131	12 31 17 MM DD YY

Street Address	City	County	State	Zip Code
1045 Scott Dr	Prescott	Yavapai	Az	86301

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

A. F9 03

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

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

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

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Ownership: F12 03

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

Owned or leased by Multi-Facility Organization: F13 Yes ☑ No ☐

Name of Multi-Facility Organization: F14
Bandera Healthcare Services, Inc.

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

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

Does the facility currently have an organized residents group?	F24	Yes ☑	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☑
Does the facility conduct experimental research?	F26	Yes ☐	No ☑
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☑

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

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F29 NA
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31 NA

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

FACILITY STAFFING

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

Name of Person Completing Form	Brigham Curran	Time	9:45am
Signature		Date	1/24/2017

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

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035131	11 F75	56 F76	17 F77	84 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 2	F80 50	F81 32
Dressing	F82 0	F83 75	F84 9
Transferring	F85 0	F86 64	F87 20
Toilet Use	F88 0	F89 70	F90 14
Eating	F91 23	F92 52	F93 9

A. Bowel/Bladder Status

F94 9 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 8 ?

F96 50 Occasionally or frequently incontinent of bladder

F97 36 Occasionally or frequently incontinent of bowel

F98 50 On urinary toileting program

F99 36 On bowel toileting program

B. Mobility

F100 1 Bedfast all or most of time

F101 64 In a chair all or most of time

F102 0 Independently ambulatory

F103 19 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 16 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 16 ?

C. Mental Status

F108-114 – indicate the number of residents with:

F108 0 Intellectual and/or developmental disability

F109 30 Documented signs and symptoms of depression

F110 14 Documented psychiatric diagnosis (exclude dementias and depression)

F111 20 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 8 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 7 ?

F117 68 Receiving preventive skin care

F118 0 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 6 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 0 Dialysis

F123 1 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 35 Respiratory treatment

F125 0 Tracheostomy care

F126 1 Ostomy care

F127 0 Suctioning

F128 19 Injections (exclude vitamin B12 injections)

F129 0 Tube feedings

F130 16 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 20 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 5 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 43 Any psychoactive medication

F134 8 Antipsychotic medications

F135 22 Antianxiety medications

F136 32 Antidepressant medications

F137 2 Hypnotic medications

F138 17 Antibiotics

F139 71 On pain management program

G. Other

F140 3 With unplanned significant weight loss/gain

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

F142 0 Who use non-oral communication devices

F143 84 With advance directives

F144 42 Received influenza immunization

F145 18 Received pneumococcal vaccine

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

Signature of Person Completing the Form	Title	Date
Lori Cooley	RN	1/24/2017

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 %

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CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 01/13/2013 thru 01/13/2017
Arizona

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 - 12/23/2015

Prior 3 Survey 03/2012	S/S Code	Prior 2 Survey 05/2013	S/S Code	Prior 1 Survey 08/2014	S/S Code	Current Survey 11/05/2015	S/S Code	Plan/Date of Correction		Requirement
		X	D						REQ	F0157-NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
		X	B						REQ	F0160-CONVEYANCE OF PERSONAL FUNDS UPON DEATH
									REQ	F0204-PREPARATION FOR SAFE/ORDERLY
									REQ	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
									REQ	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
		X	D	X	D	X C	D	12/13/2015	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
X	D								REQ	F0248-ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES
									REQ	F0272-COMPREHENSIVE ASSESSMENTS
		X	D						REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
		X	D						REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
		X	E						REQ	F0280-RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
									REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
		X	D						REQ	F0282-SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
		X	D			X C	D	12/13/2015	REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
		X	D						REQ	F0312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
X	D	X	E	X	D				REQ	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
									REQ	F0325-MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE
									REQ	F0327-SUFFICIENT FLUID TO MAINTAIN HYDRATION
									REQ	F0328-TREATMENT/CARE FOR SPECIAL NEEDS
		X	D	X	D				REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
									REQ	F0333-RESIDENTS FREE OF SIGNIFICANT MED ERRORS
									REQ	F0334-INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS
		X	D	X	F	X C	D	12/13/2015	REQ	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
									REQ	F0411-ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
		X	D						REQ	F0428-DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON
X	F								REQ	F0431-DRUG RECORDS, LABEL/STORE DRUGS &

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

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 01/13/2013 thru 01/13/2017

GRANITE CREEK HEALTH & REHABILITATION CCN: 035131

Prior 3 Survey	S/S Code	Prior 2 Survey	S/S Code	Prior 1 Survey	S/S Code	Current Survey 11/05/2015	S/S Code	Plan/Date of Correction		Requirement
03/2012		05/2013		08/2014						
						X C	D	12/13/2015	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
									REQ	F0500-OUTSIDE PROFESSIONAL RESOURCES-
									REQ	F0502-ADMINISTRATION
				X	B				REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey	S/S Code	2012 HC Prior 2 Survey	S/S Code	2012 HC Prior 1 Survey	S/S Code	2012 HC Current Survey 11/05/2015	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
03/2012		05/2013		08/2014						
		X	D						STD	K0232-Aisle, Corridor, or Ramp Width
									STD	K0281-Illumination of Means of Egress
									STD	K0321-Hazardous Areas - Enclosure
									STD	K0353-Sprinkler System - Maintenance and Testing
									STD	K0363-Corridor - Doors
									STD	K0511-Utilities - Gas and Electric
									STD	K0923-Gas Equipment - Cylinder and Container Storag

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

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 01/13/2013 thru 01/13/2017

GRANITE CREEK HEALTH & REHABILITATION CCN: 035131

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	4	5	13	3
Health Total	4	5	13	3
Life Safety Code	0	0	1	0
Life Safety Code + Health	4	5	14	3

Complaint Survey Information

Survey Date	Status
11/05/2015	Substantiated
08/28/2014	Unsubstantiated
05/23/2013	Substantiated
03/22/2012	Unsubstantiated

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 01/13/2013 thru 01/13/2017

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

LTC Resident Census

Resident Census on 11/05/2015
Total: 72
Medicare: 9
Medicaid: 46
Other: 17

Total Certified Beds: 128

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