



QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES

NURSING CARE INSTITUTION



Issued To:

Watson Woods Healthcare, Inc.
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-919.

COMPONENTS	CRITERIA MET		QUALITY PERFORMANCE SCALE	
	Yes	No		
I. Nursing Services	25	0	"A" Excellent	X
II. Resident Rights	25	0	"B"	
III. Administration	25	0	"C"	
IV. Environment and Infection Control	15	0	"D"	
V. Food Services	10	0	"A" 90-100 Points "B" 89-80 Points "C" 70-79 Points "D" 69 or fewer Points	
TOTAL CRITERIA MET	100	0		

License Effective

From: 5/23/19

Issued: 6/11/19

Number: NCI-2728

Recommended By: Diane Eckles

Issued By: Cy3m
Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

YAVAPAI COUNTY
COMMUNITY HEALTH SERVICE
Environmental Health Unit

Prescott Office: 928-771-3149
1090 Commerce Drive
Prescott, AZ 86305



Cottonwood Office: 928-639-8138
10 S 6th Street
Cottonwood, AZ 86326

Prescott Valley Office: 928-583-1015
3212 N Windsong Drive
Prescott Valley, AZ 86314

Foodservice Establishment Inspection Report

Establishment Information

Facility Name	Facility Type
Granite Creek Health & Rehab Ctr	Health Care Facility (food)
License #	Facility Telephone #
13383	928 778-9603
Facility Address	
1045 Scott Dr	
Prescott, AZ	
Licensee Name	Licensee Address
Watson Woods Healthcare Inc	27101 Puerta Real # 450
	Mission Viejo, CA
	92691

Inspection Information

Inspection Type	Inspection Date	Total Time Spent
Routine	February 25, 2019	0.75 hours

Smoke Free Arizona Act

Compliant	Evidence of Non-Compliance
Yes	

Equipment Temperatures

Description	Temperature (Fahrenheit)
#1 WIC	39
#2 Hot holding	158-189
#3 Freezer	ok

Food Temperatures

Description	Temperature (Fahrenheit)
#1 watermelon, milk, ham	40,39,39
#2 pork, beef, pasta, hamburger	158,178,164,189

Warewashing Information

Machine Name	Sanitization Method	Thermo Label	PPM	Sanitizer Name	Sanitizer Type
3-Comp	manual		200	quat	chemical
Pro Clean	Manual		0.00	chlorine	chemical
Dishmachine	Manual		100	quat	chemical
Sani Buckets					

Food Safety

Certified Manager	Food Safety Plan In Place
Yes	Yes
Number Of Food Worker Cards	Number of Employees
8	8

OPERATOR - The violations in operating procedure or physical arrangement indicated below must be corrected by the next routine inspection or by a date specified in this report.

Total # 1

Repeated # 0

Observed Priority Violations

16

4-703.11 (A-C) - HOT WATER AND CHEMICAL- SANITIZING METHOD

Observation: **(CORRECTED DURING INSPECTION):** No sanitizer measured at the final rinse of the chemical dish machine. Sanitizer bucket was empty.

Corrective Action(s): Maintain a sanitizer rinse of 50 ppm chlorine. Adjust or repair dish machine as needed. *Manually wash, rinse and sanitize at the 3-compartment sink until the dish machine is in proper operation. Operator replaced sanitizer. Equipment was primed and working properly Correct By: 25-Feb-2019

Observed Priority Foundation Violations

Total # 0

Repeated # 0

Observed Core Violations

Total # 2

Repeated # 0

41

3-304.14 (A-F) - WIPING CLOTHS, USE LIMITATION

Observation: Wiping cloths stored in a sanitizer solution at <100 ppm.

Corrective Action(s): Maintain the sanitizer solution strength at 200-400ppm quat. Correct By: 25-Feb-2019

55

6-201.11 - FLOORS, WALLS, AND CEILINGS (CLEANABILITY)

Observation: The Walls and ceiling are patched with grout/spackle in large segments and is no longer smooth easily cleanable

Corrective Action(s): Wall, and ceiling coverings and ceilings must be designed, constructed, and installed to be smooth and easily cleanable. Make necessary repairs or improvements to meet these requirements. Use semi gloss or gloss paint or other approved wall covering like FRP Correct By: 11-Mar-2019

Comments

Certification of Bill of Rights

I acknowledge that I was notified of my inspection and due process rights at the start of this inspection as I read and reviewed with the inspector the Notice of Inspection Rights/Bill of Rights (incorporated herein and identified as Attachment "A") with the inspector.

Yes

Person in Charge

CAO/Hicks

Sanitarian

Jon Groulx
Jon Groulx

YAVAPAI COUNTY COMMUNITY HEALTH SERVICES
ESTABLISHMENT INSPECTION REPORT
NOTICE OF INSPECTION RIGHTS AND BILL OF RIGHTS

A.R.S. §§ 11-1603, 41-1001.01(C) and 41-1009
ATTACHMENT "A"
ALL BUSINESS PROVISIONS INCLUDED

This inspection is conducted by Yavapai County Community Health Services ("Department") in accordance with Arizona Revised Statutes ("A.R.S.") under Title 11 (Chapter 11), Title 36 (Chapters 1, 6, 8, and 39), and Title 41 (Chapter 6), Arizona Administrative Code ("A.A.C."), Title 9, Chapter 8, Articles 1-8, 13, Yavapai County Health Code and Ordinance ("YCHCO") and 2009 U.S. Food, Drug and Administration Code ("2009 FDA Code"). Some of the activities during the inspection may include, but are not limited to, a facility premise inspection, review of records, interview with staff, and review of services offered. Upon entry of premises, the Department inspector shall present photo identification ("ID").

1. The inspection is conducted in accordance with A.R.S. §§ 11-1602(3) and 41-1001.01(7), and the above cited authority, for the purpose of:
 - Conducting a complaint investigation; or
 - Determining compliance regarding any premise if the Department believes a violation relating to sanitation health exists.
2. The Department inspector shall disclose any applicable fees in accordance with A.R.S. §§ 11-1603 and 41-1001.01(3). There is no fee for this inspection unless the inspection is one of the following: Repeat re-inspection, Compliance inspection or Plan Review.
3. An authorized on-site representative of the regulated person may accompany the Department inspector on the premises, except during confidential interviews or if the inspection pertains to fire and life safety inspection of areas that are accessible to the general public or a food and swimming pool inspection.
4. You have the right to have:
 - Copies of any original documents taken by the Department during the inspection, if permitted by law to take the original documents;
 - A split of any samples taken during the inspection if the split of any samples would not prohibit an analysis from being conducted or render an analysis inconclusive and copies of any analysis performed on such samples taken; and
 - Copies of any documents relied upon to determine compliance with licensure or regulatory requirements.
5. If the information and documents provided to the Department become a public record, the regulated person may redact trade secrets, proprietary and confidential information unless the information and documents are confidential per statute.
6. Each person interviewed will be informed that statements made by the person may be included in the inspection report.
 - Participation in the interview is voluntary unless the person is legally compelled to participate in the interview.
 - If the conversation is tape recorded, the interviewed person will be informed that the conversation is being tape recorded.
 - The person is allowed at least 24 hours to review and revise any written witness statement that is drafted by the Department inspector, auditor or regulator and on which the Department inspector, auditor or regulator requests the person's signature.
 - The inspector, auditor or regulator may not prohibit the regulated person from having an attorney or any other experts in their field present during the interview to represent or advise the regulated person.
7. You and your staff have the opportunity to provide any information that would clarify an issue. If the inspection report contains deficiencies identified during the inspection, the Department shall provide the regulated person an opportunity to correct the deficiencies identified during the inspection, unless contrary to state or federal law or if the Department determines the deficiencies are intentional, not correctable within a reasonable amount of time, evidence of a pattern of noncompliance, or a risk to any person, public health, safety, welfare or the environment.
8. Upon completion of the inspection or complaint investigation, the Department inspector will:
 - Conduct an exit interview and informally disclose his/her findings;
 - Afford you the opportunity to identify corrective actions that can be taken to comply with the law; and
 - Provide you with a copy of the inspection report or notify you that a copy of the inspection report will be provided to you within 30 working days after the inspection.
9. A Department decision pursuant to A.R.S. §§ 11-1603(E)-(F) and 41-1009(E)-(F) is not an appealable county action.
10. You may contact Cecil Newell at (928) 771-3149 to inquire about the process by which a regulated person, including small businesses, may file a complaint. See also, A.R.S. § 41-1001.01(9)-(10). In addition, you may contact the AZ Ombudsman Citizens' Aide at www.azoca.gov if you have already made a reasonable effort with the Department to resolve a problem, but have not been successful.
11. For questions regarding the inspection or for further information about your due process rights concerning an appeal of a final decision based upon inspection results, you may contact: Cecil Newell, Yavapai County Community Health Services, 1090 Commerce Drive, Prescott, AZ 86305, Phone: (928) 771-3149. You may also seek assistance from AZ Ombudsman Citizens' Aide at www.azoca.gov.
12. You may participate in the rule development process. See A.R.S. §§ 11-1602(11) and 41-1001.01(5)-(6), (8)-(9).
13. Your due process rights relating to an appeal of a final decision, based upon inspection results, are set forth in A.R.S. §§ 12-901 to 12-914, 36-183.04(E)-(F), 41-1061 to 41-1066, and YCHCO. For copies of the related statutes or YCHCO, please contact the Department at (928) 771-3149. You may be eligible for fees and expenses reimbursement if you prevail as set forth in A.R.S. §§ 11-1603(1) and 41-1001.01(1)-(2).
14. The inspector, auditor or regulator may not take any adverse action, treat the regulated person less favorably or draw any inference as a result of the regulated person's decision to be represented by an attorney or advised by any other experts in their field.
15. The Department inspector may file a compliance action against you arising from the inspection or compliance investigation, which applies to both new and amended compliance inspections, in accordance with the statute of limitations set forth in A.R.S. § 12-550.
16. As provided in A.R.S. § 11-1604(D), you are entitled to have the Department not request or initiate discussions about waiving any of the rights prescribed in this Notice of Inspection Rights. See A.R.S. § 11-1602(10).
17. The Department inspector presented ID and reviewed with me the above information. I read the disclosures herein and understand my inspection and due process rights as listed. Although I may decline to sign this form, I understand the Department may proceed with the inspection.

Regulated Person Representative Name

Print:

Signature and date

C. D. Hickey

25-Feb-2019

Inspector Name

Print: Jon Groulx

Signature and date

Jon Groulx

25-Feb-2019

☐ Regulated person or representative refused to sign form. ☐ Regulated person or on-site representative is not present.

The Notice of Inspection Rights and related Regulatory Bill of Rights, Small Businesses (A.R.S. § 41-1001.01) or Regulatory Bill of Rights (A.R.S. § 11-1602) are available at the Department's website: <http://www.yavapaihealth.com/environmental-health/>.

Prescott Fire Department

1700 Iron Springs Rd.

Phone: (928) 777-1700 Fax: (928) 776-1890 TDD: 445-6811

Date Inspected: 8/3/2018

Business Name: GRANITE CREEK HEALTH AND REHAB Resp. Station: FP Zone: 202 District: 0439
 Address: 1045 SCOTT DR PR Suite/Apt: PRESCOTT Zip: 86301
 Business Phone: (928) 778-9603 Fax: _____
 Vacant Suite: _____ Vacant Bldg: _____ New Business: _____ Business Relocation from: _____

Prop Owner Name: STAVE PROPERTIES, LLC Prop Owner Add: 14020 N NORTHSIGHT BL
 Prop Owner City: SCOTTSDALE Prop Owner State: AZ Prop Owner Zip: 85260
 Owner Ph1: _____ Owner Ph2: _____ Owner Ph3: _____
 Bus Owner Name: WATSON WOODS HEALTHCARE Bus Owner Add: 27101 PUERTA REAL Apt: 450
 Bus Owner City: MISSION VIEJO Bus Owner State: CA Bus Owner Zip: 92691
 Owner Ph1: (949) 540-1717 Owner Ph2: _____ Owner Ph3: _____
 Mailing Name: WATSON WOODS HEALTHCARE Mailing Address: 27 PUERTA REAL Apt: 450
 City: MISSION VIEJO State: CA Zip: 92691
 RP1: STAVE PROPERTIES, LLC Ph 1: _____ Ph 2: _____ Key Holder: X TP: _____
 RP2: HODGESON-SHAWN Ph 1: (928) 308-5767 CELL Ph 2: (928) 202-6531 CELL Key Holder: X TP: _____
 Add'l Contact Types: Manager [M] Business Owner [B] Prop Owner [P] Resp Party [RP] Resident [R] Contact [C] Other [O]

Prop Use: 24-HOUR CARE Mixed Prop: MEDICAL USE Complex: _____ Building Status: IN NORMAL US Building Class: HEALTH-CARE
 Business Sq. Ft.: 15,000 Stories Above: 1 Stories Below: _____ AED: NURSES STATION - 1
 Detectors: PRESENT Detector Type: MORE THAN ONE Description: _____
 Auto Extinguishing Sys: 1 Desc: WET PIPE SPRINKLER SYSTEM Sprinkler Sys Pressure (SPRI): _____ Top: 75 Bottom: 70
 Sprinkler Riser Location (RISR): ADMINISTRATIVE HALLWAY
 Fire Alarm Monitor Co (ALRM): ADT SECURITY SERVICES INC
 FACP Location (ALRL): CENTER NEAR NURSING STATION
 Knox Box Location (KEYB): ON BEAM N OF MAIN ENTRANCE
 Fire Dept Connection Location (FDCN): REMOTED TO NE CORNER OF BLDG.

Fire Ext Tag DT: 10/1/2017 Sprinklr Tag DT: 10/1/2017 Fire Alm Tag DT: 10/1/2017 Keys Test DT: 1/19/2018 Hood/Booth Tag DT: 1/1/2018
☒ Detectors ☒ FID Connection ☐ Gate - Keys Req ☐ Guards ☒ Hood System ☒ Sprinkler Sys
☐ Dogs ☐ Fire Alarm Sys ☐ Gate - No Keys ☐ HazMat ☒ Knox Box ☐ Standpipe

Fire Code Section	THE FOLLOWING VIOLATIONS OF THE INTERNATIONAL FIRE CODE SHALL BE CORRECTED IMMEDIATELY	Date Corrected
703.1	ADJUST FIRE DOORS FROM LOBBY	
315.3.1	STAGE 18" BELOW SPRINKLER HEAD - WITHIN STAGE	

Reinspection Date:	ReCheck By:	Date:	ReCheck By:	Date:	ReCheck By:	Date:	Legal Action:
8/17/2018							

Received By:	Inspector:	Station:	Shift:	Stn. Shift Inspecting:
<i>[Signature]</i>	M. WARD/P. NICH	FP		C FP 1

RANGE GUARD

This inspection is intended for your safety and the safety of the citizens of the City of Prescott. The items noted above are violations of the International Fire Code as adopted by the City of Prescott. This is an official notice of violation(s) requiring immediate correction. Failure to comply with these requirements may lead to legal action, criminal or civil penalties. For information concerning this inspection, call 928-777-1760



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

July 3, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Brian Lorenz, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Lorenz:

On July 3, 2019, an offsite review 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 the State participation requirements to operate a nursing home in the State of Arizona. Enclosed is the **State Revisit Report form**, which indicates the licensee to be in substantial compliance based on an allegation of compliance, and acceptable plan of correction. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

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

Sincerely,

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

Enclosure

Douglas A. Ducey | Governor Cara M. Christ MD, MS | Director

150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247 P | 602-364-2690 F | 602-324-0993

W | azhealth.gov

Health and Wellness for all Arizonans

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/03/2019
---	---	---	--

NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
{Y 000}	Initial Comments The follow up State Annual and complaint investigation survey was conducted 7/3/19, there were no deficiencies cited.	{Y 000}		

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

TITLE

(X6) DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER NCI-2728	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 7/3/2019	Y3
NAME OF FACILITY GRANITE CREEK HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1045 SCOTT DRIVE PRESCOTT, AZ 86301		

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 Y0339	Correction	ID Prefix Y1477	Correction	ID Prefix	Correction
Reg. # R9-10-403.C.2.b.	Completed	Reg. # R9-10-414.B.3.b.	Completed	Reg. #	Completed
LSC	07/01/2019	LSC	07/01/2019	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	
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 <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>DA</i>	DATE 7/3/19	SIGNATURE OF SURVEYOR <i>Dale Colon</i>	DATE 7/3/19
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/23/2019		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		



ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

June 11, 2019

Receipt Of This Notice Is Presumed To Be 06/11/2019
Important Notice - Please Read Carefully

Brian Lorenz, Administrator
Granite Creek Health & Rehabilitation Center
1045 Scott Drive
Prescott, Arizona 86301

Dear Mr. Lorenz:

Thank you for the courtesy and cooperation extended to our staff during the recent inspection of your facility.

Enclosed is a statement of **STATE** deficiencies noted during the inspection of your facility on May 23, 2019. A Plan of Correction (PoC) for the deficiencies must be submitted. This plan must be both specific to the problems noted and general to the overall process involved.

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 be advised that your plan of correction will be available as a public document for review by interested parties.

Please place your plan of correction in the space provided in the right column of the statement of deficiencies and return the original to this office no later than June 21, 2019. You must include all pages of the Statement of Deficiencies when submitting your PoC. Plans of correction sent via fax will not be accepted. Please ensure to retain a copy for your files. If the plan of correction is not received by this Office on or before this date, state enforcement action may be taken.

Douglas A. Ducey | Governor Cara M. Christ MD, MS | Director

150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247 P | 602-364-2690 F | 602-324-0993

W | azhealth.gov

Health and Wellness for all Arizonans

Granite Creek Health & Rehabilitation Center

June 11, 2019

Page Two

Informal Dispute Resolution - You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document due **10 days from receipt of this letter**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision. If you have any questions, please call: Diane Eckles, Bureau Chief, Bureau of Long Term Care 150 North 18th Avenue, #440, Phoenix, Arizona 85007 at (602) 364-2690.

Sincerely,



Diane Eckles
Bureau Chief

DE:dc


Douglas A. Ducey | Governor Cara M. Christ MD, MS | Director

150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247 P | 602-364-2690 F | 602-324-0993

W | azhealth.gov

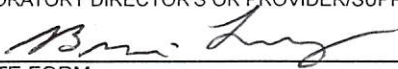
Health and Wellness for all Arizonans

ADHS LICENSING SERVICES

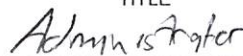
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
Y 000	Initial Comments The State compliance survey was conducted on May 20, through May 23, 2019, in conjunction with the following Complaint investigations: AZ00153176 and AZ00156579. The following deficiencies were cited:	Y 000	This Plan of Correction is submitted to meet the requirements established by state law. This Plan of Correction constitutes this facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited.	
Y 339	R9-10-403.C.2.b. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: R9-10-403.C.2.b. Cover the provision of physical health services and behavioral health services; This RULE is not met as evidenced by: Based on clinical record review, staff interviews and policy review, the facility failed to implement their policy regarding physician orders, by failing to ensure that 1 of 21 sampled residents (#81) received treatments as ordered by the physician. Findings include: Resident #81 was admitted on 12/28/18 and readmitted on 2/23/19, with diagnoses that included acute and chronic congestive heart failure, acute respiratory failure with hypoxia and pneumonia.	Y 339	 (Initials) <u>Y 339</u> <u>Corrective action for residents found to have been affected by this deficiency:</u> Resident #81 has been discharged. <u>Corrective action for residents that may be affected by the deficiency:</u> Residents with treatment orders and daily weight orders may be affected. <u>Measures that will be put into place to ensure that this deficiency does not recur:</u> Licensed nurses were re-inserviced on following physician orders and documentation of implementation of physician orders.	



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



TITLE



(X6) DATE

6/21/19

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
Y 339	<p>Continued From page 1</p> <p>The admission MDS (Minimum Data Set) assessment dated 1/4/19 included the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact.</p> <p>A physician's order dated February 22, 2019 included to check oxygen saturation levels (O2 sats) and liter flow every shift; and to check O2 sats every shift on room air, when exerting himself.</p> <p>On February 24, 2019, a physician's order revealed for oxygen 1-4 liters per minute, per nasal cannula continuous and titrate to keep O2 sats greater than 90% every shift.</p> <p>Review of the February 2019 Medication Administration Record (MAR) revealed the above orders. However, there was no documentation that the O2 liter flow and O2 sats were checked on February 27 and 28, during the evening shift.</p> <p>According to the March 2019 MAR, there was no documentation that the O2 liter flow and O2 sats were checked on March 2.</p> <p>Regarding the physician orders for weights:</p> <p>A physician's order dated February 23, 2019 included for daily weights and to notify the physician of any weight change greater than 3 lbs in one day.</p> <p>Review of the March 2019 MAR revealed the resident weighed 174 pounds on March 4. Further review revealed that on March 5, the resident's weight was 180.4 pounds.</p>	Y 339	<p><u>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:</u></p> <p>Twice weekly audits of documentation of treatment and daily weight orders including any notifications will be done.</p> <p>Corrective action will be implemented for any nurse not documenting the completion of physician treatment and weight notification orders.</p> <p>Findings and analysis will be reported to the facility's QAA Committee monthly.</p> <p>Responsible: Director of Nursing Services.</p>		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
Y 339	<p>Continued From page 2</p> <p>A nursing progress note dated March 5, 2019 stated the resident was alert, oriented x 4 and was anxious/agitated. The note stated the resident had an episode of anxiety today due to his breathing, feeling like he was not oxygenating well. Sats were checked and he was 90% on 2 liters of oxygen. A Small Volume Nebulizer (SVN) treatment was administered and he felt "a little better." This note did not address the resident's weight gain or that the physician was notified of the weight gain.</p> <p>Review of the clinical record revealed there was no documentation that the physician had been notified of the resident's weight gain at this time as ordered.</p> <p>An interview was conducted on May 22, 2019 at 12:09 p.m., with a Licensed Practical Nurse (LPN/staff #68). She stated the nurses work three shifts; days, evenings and night shift. She acknowledged there was missing documentation on the February and March MAR's for O2 monitoring. She also stated the resident's 6.4 lb weight gain on March 5 should have been immediately reported to the physician. She said her process would be to follow the physician's order.</p> <p>An interview was conducted on May 22, 2019 at 8:31 a.m., with the Director of Nursing (DON/staff #142). He stated his expectation is for the nurses to follow the physician's orders as they are written.</p> <p>The facility policy on Physician Orders dated August 2018 stated it is the policy of the facility to accurately implement orders...in accordance with the resident's plan of care.</p>	Y 339			

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
Y1477	Continued From page 3	Y1477			
Y1477	<p>R9-10-414.B.3.b. Comprehensive Assessment; Care Plan</p> <p>R9-10-414.B. An administrator shall ensure that a care plan for a resident:</p> <p>R9-10-414.B.3. Ensures that a resident is provided nursing care institution services that:</p> <p>R9-10-414.B.3.b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment.</p> <p>This RULE is not met as evidenced by: Based on clinical record reviews, staff and resident interviews and policy and procedures, the facility failed to assist residents in maintaining their highest practicable well-being, by failing to ensure that care and assistance were provided to one resident (#30) with a prosthesis which did not fit properly, and by failing to thoroughly assess a newly identified stage 2 pressure ulcer and notify the physician for treatment orders for one resident (#14).</p> <p>Findings include:</p> <p>-Resident #30 was admitted on April 13, 2017, with diagnoses that included ortho aftercare following surgical amputation of left leg below knee, chronic multifocal osteomyelitis and type 2 diabetes mellitus.</p> <p>Review of a physician's progress note dated 10/5/18 revealed the following: Evaluated and measured patient for new prosthesis. Current</p>	Y1477	<p><u>Y 1447</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Resident #30 has an appointment with a prosthetic company on June 21, 2019 for re- measurement and fitting of a new prostheses. Facility was unable to obtain an earlier appointment.</p> <p>Residents #14 has had a comprehensive wound assessment completed weekly by the facility's certified wound nurse, and by a contracted certified wound doctor. Treatments are being administered as ordered, and new pressure relieving interventions have been implemented,</p> <p><u>Corrective action for residents that may be affected by the deficiency:</u></p> <p>Residents with prostheses may be affected and have been reviewed by therapy to assure fit and wear. Any resident who may have a change of condition of skin integrity with wounds may be affected.</p> <p>Any resident with a change of condition of skin integrity with wounds may be affected.</p>		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
Y1477	<p>Continued From page 4</p> <p>socket and foot no longer fit or function well. Will follow up for casting/scanning for new prosthesis.</p> <p>However, there was no clinical record documentation that the new prosthesis was obtained for the resident or the rationale as to why this was not done from October 2018 through January 2019.</p> <p>A nursing progress note dated February 19, 2019 included a call was placed to the Nurse Practitioner (NP) to report a deep vein thrombosis was discovered via venous Doppler in the resident's right lower extremity (RLE).</p> <p>A quarterly MDS assessment March 23, 2019 revealed the resident scored 10 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The MDS also noted that the resident used a wheelchair.</p> <p>An Activities of Daily Living (ADL) care plan dated April 2, 2019, revealed the resident required assistance with ADL's related to decreased mobility, deconditioning and weakness. The goal was for the resident to gradually increase to an independent level in all ADL's including bed mobility, transfers, dressing, grooming, toilet use and personal hygiene through the next review. An intervention included for the Restorative Nurse Assistant (RNA) program: lower extremity strengthening exercises three times per week.</p> <p>Review of a Physical Therapy (PT) Evaluation and Plan of Treatment dated May 1, 2019, revealed the following goals: the resident will safely perform bed mobility tasks with modified independence and functional transfers with stand by assistance. The approaches included for therapeutic exercises and activities, manual</p>	Y1477	<p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Physical and occupational therapists were re-inserviced on follow-up for residents with ill-fitting prostheses. Licensed nurses and Unit Secretary were re-inserviced on follow-up appointments for residents with ill-fitting prosthetic devices.</p> <p>Licensed nurses were re-inserviced that a change in skin integrity involving a wound requires notification of physician for treatment orders to avoid a delay in treatment. Licensed nurses were re-inserviced to notify the facility's wound nurse for a comprehensive assessment of the wound.</p> <p><u>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:</u></p> <p>Bi-monthly audits will be completed on residents with prosthetic devices for fit and needed follow-up appointments.</p> <p>Weekly audits of weekly skin assessments and progress notes will be completed on any resident with new wounds to determine if there is a delay in treatment or assessment.</p> <p>Findings and analysis will be reported to the QAA Committee monthly.</p> <p>Responsible: Director of Rehabilitation Responsible: Director of Nursing Services</p>	

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
Y1477	<p>Continued From page 5</p> <p>therapy and neuromuscular reeducation. The resident's goal was to get better at transfers and eventually walk again. Per the evaluation, the resident demonstrates good rehab potential as evidence by active participation in skilled treatment, able to make needs known and motivated to participate.</p> <p>The PT evaluation also included the resident has had a significant decline over the past several months, due to a diagnosis of DVT to the right lower extremity and medical decline as well. He previously required 1 person assist with mobility and has had a prosthesis for his left lower extremity, but it does not fit properly. He has been non-ambulatory greater than 6 months and in bed the majority of time in the past few months. Resident is starting to feel better and is willing to participate with skilled PT. The evaluation did not include any plan to address the resident's prosthesis, which did not fit properly.</p> <p>An interview was conducted on May 20, 2019 at 10:03 a.m., with resident #30. He stated the prosthesis for his left lower leg is too small for his stump. He stated that staff are aware and is doing nothing about it. He said he used to wear his prosthesis before he got a blood clot in his other leg, but since he got the blood clot he has been laying in bed, and it no longer fits. The resident stated that with the prosthesis it made it easier to do the PT exercises and that he would like to get a new one that fits.</p> <p>An interview was conducted on May 22, 2019 at 8:16 a.m., with a Certified Nursing Assistant (CNA/staff #65). She stated the resident does have a prosthetic, but it doesn't fit him any more. She said she had not passed on the information that the prosthesis may be too small, because</p>	Y1477			

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
Y1477	<p>Continued From page 6</p> <p>she doesn't always work the same hall and she hasn't remembered to tell anyone.</p> <p>An interview was conducted on May 22, 2019 at 8:25 a.m., with a Licensed Practical Nurse (LPN/staff #22). She stated the resident does have a prosthesis and that he was currently receiving restorative nursing to build up strength in the leg, which had the DVT. She said she knows of no other reason for him not to wear it. She said once he gets his strength back, he has no reason for not wearing it. She stated the prosthesis fit a few months back and was unaware of whether or not it fit now.</p> <p>An interview was conducted on May 22, 2019 at 8:31 a.m., with the Director of Nursing (DON/staff #142). He stated the resident receives PT and that they would have therapy evaluate him, get the NP and/or doctor involved and have someone in to re-measure the resident's stump. He stated they could certainly get him fitted and could get a referral ordered.</p> <p>On May 22, 2019 at 8:48 a.m., an interview was conducted with a Physical Therapist (staff #16). She said that PT picked him up to reassess for transfers and strengthening exercises (in May). She said the resident gained a lot of weight and that his prosthetic leg didn't fit any more. She stated the resident comes to PT to do exercises and practices using the standing frame, and sometimes he tries to use the sliding board for transfers. She said that resident #30 seems to participate less in PT lately, and if he didn't participate they may have to drop him. She further stated that if the resident's prosthesis fit, it would definitely assist him in accomplishing his goals.</p>	Y1477			

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
Y1477	<p>Continued From page 7</p> <p>Review of the facility policy on Prosthesis revised May 2007 revealed that assisting the resident to use all needed prostheses on a daily basis is part of standard care and shall be encouraged. Direct care staff, in recognition of functional ability and dignity issues, are responsible for seeing that all residents with artificial limbs are wearing these devices unless the resident refuses. Referrals to outside services or in-house therapy departments for repair, maintenance, or replacement are to be made through the nurse and/or Social Services Department and/or resident and/or a family member.</p> <p>-Resident #14 was admitted to the facility on September 1, 2015, with diagnoses that included chronic kidney disease and cardiovascular disease.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated December 4, 2018 revealed the resident scored an 8 on the brief interview for mental status, which indicated the resident had moderate cognitive impairment. The MDS included the resident was at high risk for pressure ulcer development and did not have a current pressure ulcer. Per the MDS, the resident required extensive assistance with two staff for bed positioning.</p> <p>A care plan dated February 2019 documented a focus area of a potential for pressure ulcer development, due to immobility in bed and a history of pressure ulcer development. A goal was the resident would have no complications. Interventions included the following:</p> <p>-Notify the nurse immediately of any new areas of skin breakdown such as redness, blisters, bruises or discoloration.</p>	Y1477		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
Y1477	<p>Continued From page 8</p> <p>-Monitor/document/report to MD as necessary any changes in skin status such as appearance, color, wound healing, signs and symptoms of infection, wound size and stage.</p> <p>-Assess/record/monitor for wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician.</p> <p>-Follow facility policies and protocols for the prevention/treatment of skin breakdown.</p> <p>A weekly licensed nurse skin evaluation dated February 3, 2019 documented the identification of a wound on the right inner heel. The documentation included that treatment had been administered and documented on the Treatment Administration Record (TAR). However, there was no evidence of any measurements, a description of the wound, physician notification or the type of treatment that had been administered.</p> <p>Review of the clinical record including the physician orders, nursing progress notes, TARs and care plans revealed no evidence of the right inner heel wound until February 7, 2019.</p> <p>A weekly pressure ulcer form dated February 7, 2019 now revealed the resident had a fluid filled blister on the right medial heel, which was identified as a stage 2 pressure ulcer.</p> <p>Further review of the clinical record revealed no evidence of physician notification or any treatment orders, and there was no documentation of any treatments that had been administered on the February 2019 TAR.</p> <p>An interview was conducted with a Licensed Practical Nurse (staff #36) on May 22, 2019 at</p>	Y1477			

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2019
NAME OF PROVIDER OR SUPPLIER GRANITE CREEK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
Y1477	<p>Continued From page 9</p> <p>12:47 p.m. Staff #36 stated she completed a clinical record review and a skin problem had been identified on February 3, 2019. Staff #36 stated there was no documentation of physician notification or wound descriptors. Staff #36 stated the usual protocol is for the nurse to notify the wound nurse and or the physician. Staff stated for resident #14, a skin problem had been identified however; no further action was taken until 4 days later on February 7, 2019.</p> <p>An interview was conducted with the Director of Nursing (staff #142) on May 22, 2019 at 1:53 p.m. Staff #142 stated the facility protocol had not been put into place for this resident, because the physician had not been notified when a wound had been identified. Staff #142 stated the protocol was the same as outlined in the policy which includes that once a wound has been identified, assessed and documented, nursing shall administer treatment to the affected area as per the physician's orders. Staff #142 said that wound and skin treatments should be documented in the clinical record at the time they are administered.</p> <p>According to a facility policy regarding wound management the following was included: A resident who enters the facility without pressure ulcers does not develop pressure ulcers...and a resident having pressure ulcers receives necessary treatment and services to promote healing. Once a wound has been identified, assessed, and documented nursing shall administer treatment to the affected area as per the physician's orders. All wound and skin treatments should be documented in the clinical record at the time they are administered.</p>	Y1477			



Notice of Inspection Rights

Facility/Agency Name: Granite Creek Health & Rehabilitation Center

Address: 1045 Scott Drive

City: Prescott

Zip: 86301

Facility I.D.#: LTC0057

License #: NCI-2728

Medicare #: 035131

Date of Inspection: May 20, 2019

Survey Event ID: 49RX11

Inspector/Team Coordinator: Steve Schuman

Accompanied By: Paula Rittenhouse, Jean LaPour, Johnna High, Samantha Potter

BUREAU OF LONG TERM CARE LICENSING

This inspection is conducted under the authority of:

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

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

Administrator/Director/Agency Representative Signature

Date:

☒ Administrator/Director/Agency Representative refused to sign this form.

☐ Administrator/Director/Agency Representative or authorized on-site representative is not present.

Inspector/Team Coordinator Signature:

Date:

☒ Copy left with Administrator/Director/Agency Representative

QUALITY RATING CERTIFICATE



ARIZONA DEPARTMENT OF HEALTH SERVICES NURSING CARE INSTITUTION

Issued To: *Granite Creek*

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-919.

COMPONENTS	CRITERIA MET	
	Yes	No
I. Nursing Services	25	
II. Resident Rights	25	
III. Administration	25	
IV. Environment and Infection Control	15	
V. Food Services	10	
TOTAL CRITERIA MET	100	

QUALITY PERFORMANCE SCALE	
"A"	<input checked="" type="checkbox"/>
"B"	<input type="checkbox"/>
"C"	<input type="checkbox"/>
"D"	<input type="checkbox"/>
<p>"A": 90 to 100 points "B": 80 to 89 points "C": 70 to 79 points "D": 69 or fewer points</p>	

License Effective:

From:

To:

Issued:

Number: NCI-

Recommended By

Issued By

Assistant Director

Quality Rating Evaluation

Facility:

Phone:

Address:

Survey Date:

Contact Person:

Nursing Services:

Criteria: Criteria Met?
Pts. YES NO

The nursing care institution is implementing a system that ensures residents are provided nursing services to maintain the resident's highest practicable physical, mental, and psychosocial well-being according to the resident's comprehensive assessment and care plan.	15	<input checked="" type="checkbox"/>	
The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.	5	<input checked="" type="checkbox"/>	
The nursing care institution ensures the resident's representative is notified and the resident's attending physician is consulted if a resident has a significant change in condition or if the resident is in an incident that requires medical services.	5	<input checked="" type="checkbox"/>	

Points Yes 25

Points No _____

Comments:

Resident Rights:

Criteria:

Criteria Met?
Pts. YES NO

The nursing care institution is implementing a system that ensures a resident's privacy needs are met.	10	/	
The nursing care institution ensures that a resident is free from physical and chemical restraints for purposes other than to treat the resident's medical condition.	10	/	
The nursing care institution ensures that a resident or the resident's representative is allowed to participate in the planning of, or decisions concerning treatment including the right to refuse treatment and to formulate a health care directive.	5	✓	

Points Yes 25

Points No _____

Comments:

Administration:

Criteria:

Criteria Met?
Pts. YES NO

The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last survey or other survey or complaint investigation conducted between the last survey and the current survey.	10	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The nursing care institution is implementing a system to prevent abuse of a resident and misappropriation of resident property, investigate each allegation of abuse of a resident and misappropriation of resident's property, and report each allegation of abuse of a resident and misappropriation of resident's property to the Office of Long Term Care Licensure and as required by A.R.S. § 46-454.	5	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The nursing care institution is implementing a quality management program that addresses nursing care institution services provided to residents, resident complaints, and resident concerns, and documents actions taken for response, resolution, or correction of issues about nursing care institution services provided to residents, resident complaints, and resident concerns.	5	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The nursing care institution is implementing a system to provide social services and a program of ongoing recreational activities to meet the resident's needs based on the resident's comprehensive assessment.	1	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The nursing care institution is implementing a system to ensure that records documenting freedom from infectious pulmonary tuberculosis are maintained for each personnel member, volunteer, and resident.	1	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.	2	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.	1	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Points Yes 25

Points No _____

Comments:

Environment and Infection Control:

Criteria:

Criteria Met?
Pts. YES NO

The nursing care institution environment is free from a condition or situation within the nursing care institution's control that may cause a resident injury.	5	/	
The nursing care institution establishes and maintains a pest control program.	1	/	
The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.	1	/	
The nursing care institution ensures orientation to the disaster plan for each staff member is completed within the first scheduled week of employment.	1	/	
The nursing care institution maintains a clean and sanitary environment.	1	/	
The nursing care institution is implementing a system to prevent and control infection.	5	/	
An employee washes hands after each direct resident contact or where hand washing is indicated to prevent the spread of infection.	1	/	

Points Yes 15

Points No _____

Comments:

Food Services:

Criteria:

Criteria Met?
Pts. YES NO

The nursing care institution complies with 9 A.A.C. 8, Article 1, for food preparation, storage and handling as evidenced by a current food establishment license	1	/	
The nursing care institution provides each resident with food that meets the resident's needs as specified in the resident's comprehensive assessment and care plan.	3	/	
The nursing care institution obtains input from each resident or the resident's representative and implements recommendations for meal planning and food choices consistent with the resident's dietary needs	2	/	
The nursing care institution provides assistance to a resident who needs help in eating so that the individual's nutritional, physical, and social needs are met.	2	/	
The nursing care institution prepares menus at least one week in advance, conspicuously posts each menu, and adheres to each planned menu unless an uncontrollable situation such as food spoilage or non-delivery of a specified food requires substitution.	1	/	
The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.	1	/	

Points Yes 16

Points No _____

Comments: