State

Public Records Documents Only

Survey event:9X1V

Facility: GRANITE CREEK HEALTH & REHAB

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 5, 2023

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

Dear Mr. Cooper:

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

Enclosed is the **State Revisit Report form**, which indicates the licensee to be **in substantial compliance** based on your 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,

Monica Miller

Monica Miller
Program Specialist

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Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2728	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTI	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 An offsite follow-up survey was conducted on 8/4/2023. 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NCI-2728 Y1	A. Building B. Wing Y2	8/4/2023 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 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 Y0335 Reg. # R9-10-403.C.1.q. LSC	Correction Completed 07/18/2023	ID Prefix Y0342 Reg. # R9-10-403.C.2.e. LSC	Correction Completed 07/18/2023	ID Prefix Y2503 Reg. # R9-10-425.A.1.b. LSC	Correction Completed 07/18/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** EG	**DATE** 08/04/2023	**SIGNATURE OF SURVEYOR** Estrella Gies	**DATE** 08/04/2023
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

ADHS
LICENSING

July 19, 2023

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

Dear . Cooper:

Thank you for the courtesy and cooperation extended to our staff during the recent complaint inspection, **#9X1V11**, of your facility.

Enclosed is a statement of **STATE** deficiencies noted during the inspection of your facility on June 9, 2023. 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 provide all in-service records to include:**
  - **What was taught**
  - **When it was taught**
  - **Sign-in sheets of those who attended**
  - **Any copies of monitoring adults being done up to youir Allegation of Compliance date**

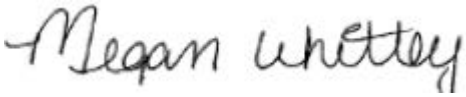
Please place your plan of correction in the space provided in the right column of the statement of deficiencies and return the original to this office no later than **July 29, 2023**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Please ensure to retain a copy 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.

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

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

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: Bureau of Long Term Care, 150 North 18th Avenue, #440, Phoenix, Arizona 85007 at (602) 364-2690.

Sincerely,



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

MW:eg

Attachments

ADHS LICENSING SERVICES

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Y 000	Initial Comments The complaint survey was conducted on May 27 through 28, 2023 for the investigation of the following intake #s: AZ00177308, AZ00177380, AZ00177846, AZ00178427, AZ00178703, AZ00178744, AZ00179758, AZ00181080, AZ00171526, AZ00182112, AZ00182760, AZ00184939, AZ00186906, AZ00187242, AZ00189809, AZ00189797, AZ00189921, AZ00190195, AZ00190183, AZ00190327, AZ00190389, AZ00190779, AZ00190899, AZ00192716, AZ00191420, AZ00192739, AZ00192997, AZ00193069, AZ00193066, AZ00193126, AZ00193350, AZ00193640, AZ00193712, AZ00194120, AZ00194896, AZ00195009, AZ00195132, AZ00195319, AZ00195321, AZ00195662, AZ00195855 and AZ00195833. 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. (Initials)	
Y 335	R9-10-403.C.1.q. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that: R9-10-403.C.1.q. Cover misappropriation of resident property; and This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and facility documents and policy, the facility failed to ensure ensure two residents (#85 and #24) were free from drug diversion.	Y 335	**Y 335** **Corrective action for residents found to have been affected by this deficiency:** Resident #85's morphine was reordered. The resident is no longer in the facility. Resident #24's morphine was reordered and is still a current resident at the facility. **Corrective action for residents that may be affected by the deficiency:** All residents have a potential to be affected. A facility wide sweep was conducted. All narcotic medication were accounted for and visually inspected.	7/28/23

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

ADHS LICENSING SERVICES

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Y 335	Continued From page 1 Findings include: -Resident #85 was admitted on July 8, 2022 with diagnoses of malignant neoplasm of bladder and colon. A physician order dated November 21, 2022 included morphine sulfate (opioid) solution 20 mg(milligrams)/mL (milliliter) give 0.5 mL by mouth every 2 hours as needed for pain 1-10. A quarterly Minimum Data Set (MDS) assessment dated January 28, 2023 included the resident was able to express ideas and wants and was able to understand others. The assessment also included the resident had received scheduled and as-needed pain medication and he had limited day to day activities in the last 5 days due to pain with the highest pain being 7/10. -Resident #24 was admitted on September 13, 2019 with diagnoses of chronic obstructive pulmonary disease and fibromyalgia. A physician's order dated February 19, 2023 included morphine sulfate solution 20mg/mL give 10 mg by mouth every 2 hours as needed for pain 1-10. A quarterly MDS assessment dated March 19, 2023 included the resident was rarely or never understood and was moderately impaired for decision making regarding tasks of daily life. Per the assessment, the resident received as-needed pain medication and that highest pain was 8/10 in the last 5 days.	Y 335	Additionally, liquid narcotics were inspected, pulled from carts and new ones were reordered. No additional concerns were noted. No additional residents were identified to be potentially affected. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were in serviced on proper narcotic counting, tracking, documentation, removal procedures, and reporting suspected drug diversion, misappropriation, and abuse. All staff were in serviced on the facility's abuse reporting policy to include EJA and abuse prevention. The ED and/or designee will review grievances with the department heads in stand-up meeting, Monday-Friday to identify any concerns and ensure appropriate follow-up has occurred. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** An audit was created to monitor for misappropriation of narcotic medications and were done Monday through Friday for 2 weeks, then weekly for one month, then randomly for 6 weeks. Findings and analysis will be reported to the QAA Committee for 3 months. Responsible: Abuse coordinator and Director of Nursing or designee.	7/18/23

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Y 335	Continued From page 2 A 5-day report on March 22, 2023 included that residents #85 and #24 were potentially affected by misappropriation of liquid morphine. Per the documentation, the liquid morphine in question was compared with other liquid morphine in the facility and was determined to be of a different color and consistency based on visual inspection. It also included that a pharmacist was interviewed and the pharmacy recommended that visual inspection was enough to allege diversion. Per the facility report this allegation was unable to be substantiated; and that, the investigation was inconclusive. Further, the report included that facility interviews indicated that staff had no prior experiences in the building with misappropriation. However, an interview was conducted on May 27, 2023 at 3:07 p.m., with a licensed practical nurse (LPN/staff #37) who stated that there was a nurse who was making medications disappear from another staff's (#50's) cart. She said that she had written "do not use this card" because it was the wrong medication and it just disappeared. She said that she noticed that residents who do not usually take their opioid medications such as morphine, were the ones that were taken and disappear. The LPN stated that she made copies of the narcotic sheets and had informed the Director of Nursing (DON) about it. An interview with a registered nurse (RN/staff #50) was conducted on May 27, 2023 at 2:43 p.m. The RN said that that facility did have a registry nurse; and that, the morphine located in the 400 hall was the wrong color. She stated that the facility placed the registry nurse on the "do not return list" after the several nurses	Y 335		7/18/23

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Y 335	Continued From page 3 complained multiple times about morphine medications having wrong color and disappearing from the medication carts during the shift of the alleged registry nurse. In an interview with a RN (staff #3) conducted on May 28, 2023 at 1:18 p.m., the RN stated that she found the morphine with the wrong color; and, she wrote this on the narcotics sheet as "unidentifiable liquid do not administer". She said the reported to the DON that the morphine was the wrong color on March 19, 2023 at 7:15 p.m. An interview with a pharmacist was conducted on June 7, 2023. The pharmacist stated that the liquid morphine sulfate was either light blue or blue green in appearance; and that, he would want to check into it if this medication were a lighter color than expected. He said that it could be watered down and that while color varied, he would still consider this as misappropriation. During an interview conducted with the DON (staff #8) on June 9, 2023 at 10:49 a.m., the DON stated that her expectation was for staff to report immediately to her or the administrator and misappropriation issues especially if it involved controlled substances. She stated that in the case of controlled substances being altered or missing, she would get interviews from staff members, notify family and residents and obtain new medications and replace the medication. Unfortunately, the DON stated that when talking with pharmacy, there was no way to definitely say that the medication had been misappropriated and/or no way to prove misappropriation as the staff who was doing it would want to act with an abundance of caution. She said that any concerns reported to her by	Y 335		7/18/23

ADHS LICENSING SERVICES

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Y 335	Continued From page 4 her staff would be acted on immediately. She said that the staff did replace the medication and reported it to their hospice provider and medical director. The facility policy on Abuse: Prevention of and Prohibition Against revealed that it is their policy that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.	Y 335		
Y 342	R9-10-403.C.2.e. 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.e. Cover infection control; This RULE is not met as evidenced by: Based on clinical record review, resident and staff interviews and facility policy review, the facility failed to establish and implement policy that cover infection control by failing to ensure that staff were not allowed to work while they were sick. Findings include: Resident #57 was admitted on April 18, 2022 with diagnoses of fibromyalgia, post-traumatic stress	Y 342	**Y 342** **Corrective action for residents found to have been affected by this deficiency:** Resident #57 remains in the facility and has been examined by the attending physician. She is receiving care and services according to her plan of care. **Corrective action for residents that may be affected by the deficiency:** All residents have a potential to be affected. A full in- house audit was conducted to identify potential exposure from staff related illnesses. No other residents were identified as affected. **Measures that will be put into place to ensure that this deficiency does not recur:** In-services were given to all staff on call off procedures for illnesses, reporting illness related symptoms to the Infection Prevention nurse (IP), and Director of Nursing (DON), and return to work policies and procedures.	7/28/23

ADHS LICENSING SERVICES

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Y 342	Continued From page 5 disorder and Major Depressive Disorder. An annual Minimum Data Set (MDS) assessment dated April 22, 2023 included the resident had intact memory and was independent to make the decisions for tasks of daily living. The assessment also included that the resident did not show signs of delirium, hallucinations or delusions and had not exhibited behavioral symptoms. An interview with resident #57 was conducted on May 28, 2023 at 2:23 p.m. Resident #57 stated that she had seen employees working sick; and that, the certified nursing assistant (CNA/staff #81) caring for her did not look good and she asked that CNA who responded with a sigh and did not answer. She said the CNA (staff #81 was very careful not to say anything; however, other staff who also were sick had told her that it was ridiculous that when other staff would call off, facility management would tell staff who were sick to come in sick because others have called in. An interview was conducted on March 27, 2023 at 3:32 p.m. with a CNA (staff #81) who stated that she was sick during her workday on Monday; and, she thought she ate something that didn't agree with her. She said she spoke with the staffing coordinator who told her that she must find her own coverage or she cannot go home. She stated that she was changing residents but had to run because she was having diarrhea. The CNA stated that she had to resort to wearing pull ups because she could not control her bowels; despite that, she was not allowed to go home. The CNA stated that she was still very sick on Tuesday which was her day off. She said she	Y 342	On-going tracking of staff related illnesses will be completed by staffing coordinator and will be reviewed by the infection preventionist. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Audits of staff call offs and reports of staff related illnesses will be done Monday thru Friday for 2 weeks, then Biweekly for 4 weeks, then randomly for 1 month. Findings and analysis will be reported to the QAA Committee for three months Responsible: DON or designee, Staffing Coordinator, Infection preventionist.	7/19/23

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Y 342	Continued From page 6 called the staffing coordinator to inform that she would not be able to make it to her Wednesday shift because she was going to the emergency room. The CNA said that the staffing coordinator told her that no one goes to the ER (emergency room) for diarrhea. The CNA said that she was given 2 types of antibiotics for bacterial colitis; and that, the hospital gave her a note saying that she could not work until the 26th. However, when she told the Director of Nursing (DON/staff #8) about this, the DON told her that she was abandoning her residents. In an interview with a registered nurse (RN/staff #3) conducted on May 28, 2023, the RN stated that she was the nurse on duty when a CNA (staff #42) almost passed out. The RN said that the CNA was nauseous and throwing up; and when she called management to get more relief, the CNA was never sent home. An interview was conducted on May 28, 2023 at 1:52 p.m. with a licensed practical nurse (LPN/staff #27) who stated that he had worked with staff who were ill during the shift. The LPN stated that when calling out, staff would contact the staffing coordinator at least 2 hours ahead of time to give her notice; and that, staff performs self-testing for COVID. The LPN said that the other day he worked with a CNA (staff #42) who was nauseous; however, he did not know if the CNA called management which was a policy when staff are sick. In an interview with a CNA (staff #49) conducted on June 9, 2023 at 10:19 a.m., the CNA stated that the facility management was making their staff work when staff were sick. The CNA stated that management instructed staff that if staff were	Y 342		7/18/23

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Y 342	Continued From page 7 sick they had to find their own coverage for their shift. The CNA said that the facility did not have a lot of core staff; however, the staff cannot call agency staff either. So, the CNA stated that staff just work even when they were sick. During an interview with the DON (staff #8) conducted on June 9, 2023 at 10:49 a.m., the DON stated that the expectation was that if a staff member was feeling sick then they are asked about their symptoms of COVID and if they have tested. However, the DON stated that the staff do not work while they are sick. She said that she had not received reports that staff were working ill in the building. The DON stated that she had provided all of the policies for staff working sick. However, review of the policies provided to the survey team revealed no policy that included that facility prohibited staff from working while sick.	Y 342		
Y2503	R9-10-425.A.1.b. Environmental Standards R9-10-425.A. An administrator shall ensure that: R9-10-425.A.1. A nursing care institution's premises and equipment are: R9-10-425.A.1.b. Free from a condition or situation that may cause a resident or an individual to suffer physical injury; This RULE is not met as evidenced by: Based on clinical record review, staff interviews and facility policy and State Agency (SA) complaint database, the facility failed to ensure	Y2503	**Y 2503** **Corrective action for residents found to have been affected by this deficiency:** Resident #62 was readmitted to the facility with an updated treatment plan. The resident has been assessed by the attending physician, and the care plan has been updated. **Corrective action for residents that may be affected by the deficiency:** All residents have a potential to be affected. A facility wide audit was conducted for potential accidental fall hazards and appropriate fall prevention interventions in place.	7/18/23

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Y2503	Continued From page 8 environment was free from a condition or situation that may cause injury for one resident (#62). Findings include: Resident #62 was admitted on May 3, 2019 with diagnoses of spinal stenosis, fibromyalgia and osteoporosis. A care plan dated May 3, 2019 revealed the resident was at risk for falls related to history frequent falls; and, required extensive assist of 1-2 with the completion of Activities of Daily Living (ADLs) and active functional mobility skills. A quarterly Minimum Data Set (MDS) assessment dated February 4, 2023 the resident was cognitively intact; and, required one-person physical assistance supervision for transfers. A care plan dated February 24, 2023 revealed the resident had osteoporosis. Interventions included to educate resident, family/caregivers on safety measures that need to be taken in order to reduce risk of falls. The fall care plan was revised on March 4, 2023 to include an intervention for staff to complete education on proper placement of food tray in room and to ensure tidiness of items. Hospital record dated March 4, 2023 included the resident had a fall, came into the ER (emergency room) and was found to have a left femoral neck hip fracture; and that, the fracture was surgically repaired. An interdisciplinary team (IDT) note dated March	Y2503	No other resident was identified as having falls related to accidental fall hazards. **Measures that will be put into place to ensure that this deficiency does not recur:** Inservice training was given to all staff on accidental fall hazards, fall interventions and ADL assistance to prevent residents from potential falls. IDT will meet Monday through Friday to review the fall management system, to include residents at risk for falls and residents that have had falls. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Audits of the fall management system will be done Monday thru Friday for 2 weeks, then biweekly for 4 weeks, then randomly for 1 month. Findings and analysis will be reported to the QAA Committee for three months. Responsible: DON or designee	7/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2728	A. BUILDING: _____ B. WING _____	C 06/09/2023

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

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Y2503	Continued From page 9 7, 2023 revealed that the IDT met to discuss the resident secondary to fall on March 4, 2023. Per the documentation, a staff heard the crash of dishes and the resident called out; and when the staff entered the resident's room, the resident was laying on her left side at the foot of the bed. It also included that the resident was assessed for injury, vital signs were taken, and the resident was assisted to her chair. According to the documentation, the resident was able to walk to her chair with walker and staff assistance but reported pain in her left hip that continued to increase. The note included that the resident was sent to the hospital for further evaluation through EMS (emergency medical services); and that, the resident was admitted for hip fracture. Further, the note included that staff were to receive education on proper placement of food tray in room and overall tidiness of room. A 5-day MDS assessment dated March 14, 2023 included the resident had a fracture related to a fall; and, required extensive 2 plus person assistance for transfers. The SA complaint database dated May 12, 2023 included an allegation that the staff had put the resident's meal tray on the resident's wheelchair seat; and, the resident went to sit down in her wheelchair not knowing meal tray was in her seat. The report included that the resident and the meal tray hit the floor resulting in the resident breaking her left hip. An interview was conducted on May 28, 2023 at 1:52 p.m. with a licensed practical nurse (LPN/staff #27) who stated the staff who brought the tray in the resident's room placed the tray on the resident's wheelchair put it on the resident's	Y2503		7/18/23

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Y2503	Continued From page 10 wheelchair; and that, resident #62 sat on a meal tray. The LPN stated that probably the resident's tray table was full. An interview was conducted with a certified nursing assistant (CNA/staff #15) on June 7, 2023 at 8:59 a.m. The CNA stated that staff were not supposed to put the meal tray on the chair; and that, the meal tray should go on the side table, and the lid on the counter. She said that if there was no room on the resident's tray table, she would set the tray with the rest of the trays or set it down by the sink until she can find a tray table. The CNA stated that she would not put the meal tray in the chair. Regarding the incident with resident #62, the CNA stated that someone placed the meal tray in seat of the wheelchair, the resident did not know and she fell. During an interview with the Director of Nursing (DON/staff #8) conducted on June 9, 2023 at 10:49 a.m., the DON said that her expectation was that when staff delivers food to resident rooms, they would greet the resident, place the tray where the resident can reach it and get the tray. She said that staff should never place the tray on the resident's wheelchair unless the resident requested it. She said she would not want the tray to be placed in the chair because of increased risk of falls and injury. Regarding resident #62, she stated that the resident had been at the facility for some time, was able to make her needs known and was well known to the facility. The DON stated that at the time of the incident, the meal tray was placed on the resident's chair; the resident went to sit on the chair and slipped off of the chair due to the tray on the chair. She said that this did not meet her expectations.	Y2503		7/18/23

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2728	A. BUILDING: _____ B. WING _____	C 06/09/2023

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Y2503	Continued From page 11 The facility policy on Fall Management System included that the facility was committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible and that each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices, and functional programs as appropriate to prevent accidents.	Y2503		7/18/23

ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

Public Health Licensing Services
Bureau of Long Term Care Facilities Licensing
NOTICE OF INSPECTION RIGHTS

Facility Name: Granite Creek Health & Rehabilitation Center License No.: NCI-2728 Event ID: 9X1V11
Address: 1045 Scott Drive, Prescott, AZ 86301 Date/Time: May 27, 2023
Compliance Officer(s): Carey Sexton, Morgan Henson Inspection Type: Complaint

The Arizona Department of Health Services ("Department") has the legal authority pursuant to A.R.S. Title 36, Chapter 4 to license and regulate health care institutions. Pursuant to A.R.S. § 36-424, health care institutions are subject to inspection by the Department.

Pursuant to A.R.S. § 41-1009, the Department hereby provides notice of the following rights and information related to this inspection:

1. The Compliance Officer(s) must present photo identification on entry of the premises.

2. This inspection is conducted pursuant to A.R.S. Title 36, Chapter 4 and A.A.C. Title 9, Chapter 10. The purpose of this inspection is to determine compliance with these Arizona Revised Statutes and Arizona Administrative Code sections.

3. Inspection fees are **NOT** applicable.

4. An authorized on-site agent of the health care institution may accompany the Compliance Officer(s) during the inspection of the licensed premises, except during confidential interviews.

5. You have the right to receive on request:

   a. Copies of any original documents taken by the Department during the inspection if the Department is allowed by law to take original documents.

   b. 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.

   c. Copies of any analysis performed on samples taken during the inspection.

   d. Copies of any documents to be relied on to determine compliance with licensure or regulatory requirements if the Department is otherwise allowed by law to do so.

6. The Compliance Officer(s) will inform each representative who is interviewed if they are being tape or video recorded during the inspection.

7. The Compliance Officer(s) will inform each representative who is interviewed during the inspection that:

   a. Statements made by the person may be included in the inspection report.

   b. Participation in an interview is voluntary, unless the person is legally compelled to participate in the interview.

   c. The Compliance Officer(s) may not prohibit the health care institution from having an attorney or any other experts in their field present during the interview to represent or advise the regulated person.

8. At the end of the inspection, the Compliance Officer(s) will conduct an exit interview to discuss the inspection and offer to review with an authorized representative the findings of the inspection and what agency actions the regulated person can expect.

9. If you have any questions regarding this inspection, you may contact: Rosemary Gleason, Bureau Chief of Long Term Care Licensing, at 150 N. 18th Avenue, Suite 440, Phoenix, AZ 85007; Phone: (602) 364-2690; E-mail: rosemary.gleason@azdhs.gov. You also may contact the Department's Ombudsman: Thomas Salow at 150 N. 18th Avenue, Suite 500, Phoenix, AZ 85007; Phone: (602) 364-1935; Email: thomas.salow@azdhs.gov.

10. If you have an issue that you cannot resolve with the Department, you may contact the Office of Ombudsman-Citizens' Aide, 3737 N. 7th Street, Suite 209, Phoenix, Arizona 85014; Phone: (602) 277-7292.

11. The Department will issue a Statement of Deficiencies (SOD) formally notifying you of the findings of the inspection within thirty working days after the inspection. At least once every month after the commencement of the inspection, the Department will provide you with an update on the status of any agency action resulting from the inspection. You will be afforded an opportunity to submit a Plan of Correction ("POC") unless the Department determines that a POC is not appropriate pursuant to A.R.S. § 41-1009(E).

12. You have an opportunity to dispute any deficiencies or language listed in the SOD through an Informal Dispute Resolution ("IDR"). To dispute a deficiency or language listed in the SOD, send a written request within ten calendar days from receipt of the SOD to Rosemary Gleason, Bureau Chief of Long Term Care Licensing, at 150 N 18th Avenue, Suite 440, Phoenix, AZ 85007; Phone: (602) 364-2690; E-mail: rosemary.gleason@azdhs.gov. The written request must include documentation that shows the licensee was in compliance at the time of 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 602-364-2690.

13. If the Department takes enforcement action based on the inspection, you have the right to request an administrative hearing pursuant to A.R.S. § 41-1092, et seq. Rights relating to the appeal of a final agency decision can be found in A.R.S. § 12-901, et seq.

14. The Department may not take any adverse action, treat the health care institution 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. If the information and documents provided to the Department's Compliance Officer(s) become a public record, the health care institution may redact trade secrets and proprietary and confidential information unless the information and documents are confidential pursuant to statute.

16. There is no statutory time limit or statute of limitations applicable to the right of the Department to file a compliance action against the regulated person arising from the inspection or audit, which applies to both new and amended compliance actions.

17. A copy of the Department's Small Business Bill of Rights is included below and is available on the Department's website (www.azdhs.gov). The Small Business Bill of Rights applies to entities that meet the definition of "small business" in A.R.S. § 41-1001.

Upon entry of these premises, the Compliance Officer(s) presented photo identification indicating that they are Arizona Department of Health Services employees, and they reviewed with me the information contained in this Notice of Inspection Rights. I have read the information and have been notified of the inspection and due process rights as listed. I understand that while I have the right to decline to sign this form, the Department's Compliance Officer(s) may proceed with the inspection.

Signature of Authorized Agent _____ Date_____

Signature(s) of Compliance Officer(s) _____ Date_____

SMALL BUSINESS BILL OF RIGHTS

To ensure fair and open regulation by state agencies, a person:

1. Is eligible for reimbursement of fees and other expenses if the person prevails by adjudication on the merits against an agency in a court proceeding regarding an agency decision as provided in A.R.S. § 12-348.

2. Is eligible for reimbursement of the person's costs and fees if the person prevails against any agency in an administrative hearing as provided in A.R.S. § 41-1007.

3. Is entitled to have an agency not charge the person a fee unless the fee for the specific activity is expressly authorized as provided in A.R.S. § 41-1008.

4. Is entitled to receive the information and notice regarding inspections and audits prescribed in A.R.S. § 41-1009.

5. May review the full text or summary of all rulemaking activity, the summary of substantive policy statements and the full text of executive orders in the register as provided in A.R.S. Title 41, Chapter 6, Article 2.

6. May participate in the rulemaking process as provided in A.R.S. Title 41, Chapter 6, Articles 3, 4, 4.1 and 5, including:

    a. Providing written comments or testimony on proposed rules to an agency as provided in A.R.S. § 41-1023 and having the agency adequately address those comments as provided in A.R.S. § 41-1052(D), including comments or testimony concerning the information contained in the economic, small business and consumer impact statement.

    b. Filing an early review petition with the governor's regulatory review council as provided in A.R.S. Title 41, Chapter 6, Article 5.

    c. Providing written comments or testimony on rules to the governor's regulatory review council during the mandatory sixty-day comment period as provided in A.R.S. Title 41, Chapter 6, Article 5.

7. Is entitled to have an agency not base a licensing decision in whole or in part on licensing conditions or requirements that are not specifically authorized by statute, rule or state tribal gaming compact as provided in A.R.S. § 41-1030(B).

8. Is entitled to have an agency not base a decision regarding any filing or other matter submitted to an agency on a requirement or condition that is not specifically authorized by a statute, rule, federal law or regulation or state tribal gaming compact as provided in A.R.S. § 41-1030(C).

9. Is entitled to have an agency not make a rule under a specific grant of rulemaking authority that exceeds the subject matter areas listed in the specific statute or not make a rule under a general grant of rulemaking authority to supplement a more specific grant of rulemaking authority as provided in A.R.S. § 41-1030(D).

10. May allege that an existing agency practice or substantive policy statement constitutes a rule and have that agency practice or substantive policy statement declared void because the practice or substantive policy statement constitutes a rule as provided in A.R.S. § 41-1033.

11. May file a complaint with the administrative rules oversight committee concerning:

    a. A rule's, practice's or substantive policy statement's lack of conformity with statute or legislative intent as provided in A.R.S. § 41-1047.

    b. An existing statute, rule, practice alleged to constitute a rule or substantive policy statement that is alleged to be duplicative or onerous as provided in A.R.S. § 41-1048.

12. May have the person's administrative hearing on contested cases and appealable agency actions heard by an independent administrative law judge as provided in A.R.S. Title 41, Chapter 6, Articles 6 and 10.

13. May have administrative hearings governed by uniform administrative appeal procedures as provided in A.R.S. Title 41, Chapter 6, Articles 6 and 10, and may appeal a final administrative decision by filing a notice of appeal pursuant to A.R.S. Title 12, Chapter 7, Article 6.

14. May have an agency approve or deny the person's license application within a predetermined period of time as provided in A.R.S. Title 41, Chapter 6, Article 7.1.

15. Is entitled to receive written notice from an agency on denial of a license application:

    a. That justifies the denial with references to the statutes or rules on which the denial is based as provided in A.R.S. § 41-1076.

    b. That explains the applicant's right to appeal the denial as provided in A.R.S. § 41-1076.

16. Is entitled to receive information regarding the license application process before or at the time the person obtains an application for a license as provided in A.R.S. §§ 41-1001.02 and 41-1079.

17. May receive public notice and participate in the adoption or amendment of agreements to delegate agency functions, powers or duties to political subdivisions as provided in A.R.S. § 41-1026.01 and Title 41, Chapter 6, Article 8.

18. May inspect all rules and substantive policy statements of an agency, including a directory of documents, in the office of the agency director as provided in A.R.S. § 41-1091.

19. May file a complaint with the office of the ombudsman-citizens aide to investigate administrative acts of agencies as provided in A.R.S. Title 41, Chapter 8, Article 5.

20. Unless specifically authorized by statute, may expect state agencies to avoid duplication of other laws that do not enhance regulatory clarity and to avoid dual permitting to the extent practicable as prescribed in A.R.S. § 41-1002.

21. Pursuant to § 41-1009(E), may correct deficiencies identified during an inspection unless otherwise provided by law.

22. Pursuant to A.R.S. § 41-1006, may contact the ADHS Ombudsman to file a complaint or seek information or assistance from the agency: Thomas Salow at 150 N. 18th Avenue, Suite 500, Phoenix, AZ 85007; (602) 364-1935; thomas.salow@azdhs.gov.

23. If the person has made a reasonable effort with the agency to resolve the problem and still has not been successful, the person may contact the Office of Ombudsman-Citizens' Aide, 3737 N. 7th Street, Suite 209, Phoenix, AZ 85014; (602) 277-7292.

The enumeration of the rights listed above does not grant any additional rights that are not prescribed in the referenced sections.