State

Public Records Documents Only

Survey event # A3PR

Facility: GRANITE CREEK HEALTH & REHAB CTR

Revised 7-2020

QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

ADHS

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	
	Yes	No
I. Nursing Services	22	3
II. Resident Rights	24	1
III. Administration	25	0
IV. Environment and Infection Control	15	0
V. Food Services	10	0
TOTAL CRITERIA MET	96	4

QUALITY PERFORMANCE SCALE	
"A" Excellent	X
"B"	
"C"	
"D"	
"A" 90-100 Points "B" 89-80 Points "C" 70-79 Points "D" 69 or fewer Points	

License Effective

From: 09/23/2021

Issued: 10/07/2021

Number: NCI-2728

Recommended By: Diane Eckles

Issued By

Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

PRESCOTT FIRE DEPARTMENT
1700 Iron Springs Road
Prescott, AZ 86305

Dennis B. Light, Fire Chief

(928) 777-1700
FAX (928) 776-1890

August 19, 2020

Mr. Shawn Helgeson
Facilities Director
Granite Creek Health and Rehabilitation
1045 Scott Drive
Prescott, AZ 86301

Dear Mr. Helgeson,

I am responding to your previous request for a fire inspection of your facility located at 1045 Scott Drive. As explained to you by Fire Inspector Mike Ward, the Prescott Fire Department is not presently conducting fire inspections of long-term care and assisted living facilities due to the current situation with Covid-19. With the exception to conditions that present an imminent threat to the staff and or occupants of such facilities we feel it is in our best interest to minimize exposing our staff to the risks associated with the preponderance of Coronavirus community spread within such facilities.

If you have any further questions, please contact Fire Inspectors Mike Ward or Pete Nigh at 928-777-1760.

Thank you for contacting us and when conditions change we would be happy to schedule the inspection.

Sincerely,

Dennis B. Light

INSPECTION REPORT

Prescott Fire Department
1700 Iron Springs Rd.
Phone:(928) 777-1700 Fax:(928) 776-1890 TDD: 445-6811

Date Inspected: 8/1/2019

ADDRESS

Business Name: GRANITE CREEK HEALTH AND REHAB | Resp. Station: FP | Zone: Z02 | 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:

CONTACTS

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: HELGESON,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]

PREPLAN

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: AREA 1 NURSE STA.

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.

C Lemm 7/2019

Fire Ext Tag DT: 10/1/2018 | Sprnklr Tag DT: ~~10/1/2017~~ 7/2019 | Fire Alm Tag DT: ~~10/1/2017~~ 10/2018 | Keys Test DT: ~~8/3/2018~~ 8/1/2019 | Hood/Booth Tag DT: ~~7/1/2018~~ 7/2019

X Detectors	X FID Connection	Gate - Keys Req	Guards	X Hood System	X Sprinkler Sys
Dogs	Fire Alarm Sys	Gate - No Keys	HazMat	X Knox Box	Standpipe

Fire Code Section	THE FOLLOWING VIOLATIONS OF THE INTERNATIONAL FIRE CODE SHALL BE CORRECTED IMMEDIATELY	Date Corrected
	NO VIOLATIONS NOTED	

Reinspection Date:	ReCheck By:	Date:	ReCheck By:	Date:	ReCheck By:	Date:	Legal Action:

Received By:	Inspector:	Station:	Shift:	Stn. Shift Inspecting:
	M. WARD 18-NIGHT	FP		C FP 1

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

Occup ID: 0000001357 Date Printed: 06/21/2019 Time Printed: 08:44 ___ Add Bus Name Cad/Street ___ Delete Business ___ Add/Change ID File

YAVAPAI COUNTY
COMMUNITY HEALTH SERVICES
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	29222 Rancho Viejo Ste 127 San Juan Capistrano, CA 92691

Inspection Information

Inspection Type	Inspection Date	Total Time Spent
Routine	July 01, 2021	0.75 hours

Smoke Free Arizona Act

Compliant	Evidence of Non-Compliance
Yes	

Equipment Temperatures

Description	Temperature (Fahrenheit)
#1 WIC	40
#2 Hot holding	138-168
#3 Freezer	ok

Food Temperatures

Description	Temperature (Fahrenheit)
#1 cheese, milk	40,41
#2 gravy, rice, veggies, chicken, mash potatoes	138,168,161,150,168

Warewashing Information

Machine Name	Sanitization Method	Thermo Label	PPM	Sanitizer Name	Sanitizer Type
3-Comp	manual		300	quat	chemical
Pro Clean Dishmachine	Manual		100	chlorine	chemical
Sani Buckets	Manual		n/o		

Food Safety

Certified Manager	Food Safety Plan In Place
Yes	Yes
Number Of Food Worker Cards	**Number of Employees**
7	7

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.

Observed Priority Violations

Total # 0
Repeated # 0

Observed Priority Foundation Violations
Total # 0 **Repeated # 0**

Observed Core Violations
Total # 0 **Repeated # 0**

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

Cindy Hicks

Cindy

Sanitarian

Jon Groulx

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

A.R.S. §§ 11-1603, 41-1001.01(C) and 41-1009
ATTACHMENT "A"
SMALL 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 ("YC HCO") 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 YC HCO. For copies of the related statutes or YC HCO, 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 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: Cindy

Signature and date: Cindy Hicks 01-Jul-2021

Inspector Name

Print: Jon Groulx

Signature and date: [signature] 01-Jul-2021

☐ 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.

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 19, 2021

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Mr. Martinez:

On October 19, 2021, an offsite revisit was conducted for your facility by the Arizona Department of Public Health, Licensing and Certification Bureau, to determine if your facility was in compliance with 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,

Sandy Farmer

Sandy Farmer
LTC Customer Service Representative IV

\sf

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 10/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION	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 offsite follow-up survey was conducted on October 19, 2021. No deficiencies were 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	10/19/2021 Y3

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

This report is completed by a 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 Y1045	Correction	ID Prefix Y1077	Correction
Reg. # R9-10-403.C.2.b.	Completed	Reg. # R9-10-410.B.4.c.	Completed	Reg. # R9-10-410.C.2.	Completed
LSC	11/12/2021	LSC	11/12/2021	LSC	11/12/2021
ID Prefix Y1235	Correction	ID Prefix Y2137	Correction	ID Prefix	Correction
Reg. # R9-10-412.B.7.	Completed	Reg. # R9-10-421.B.3.a.	Completed	Reg. #	Completed
LSC	11/12/2021	LSC	11/12/2021	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	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	We	10/19/21	[signature]	10/19/21
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 9/23/2021

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 7, 2021

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

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

Dear Mr. Martinez:

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, #A3PR11, of your facility on September 23, 2021. 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 **October 17, 2021**. 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: Diane Eckles, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007 at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:mm

Attachments

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 _____	09/23/2021

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 The State compliance survey was conducted 9/20/2021 through 9/23/2021. The census was 72. The following deficiencies were 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. ARIZONA DEPARTMENT OF HEALTH DIVISION OF PUBLIC HEALTH LICENSING OCT 15 2021 LONG TERM CARE 150 N. 18TH AVE # 440 PHOENIX, AZ 85007 This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and policy reviews, the facility failed to implement their policy to ensure that one resident's (#3) physician was notified of elevated blood sugars. Findings include: Resident #3 was admitted to the facility on 8/4/2017 and readmitted on 11/8/2020 with diagnoses that included atherosclerotic heart disease, chronic kidney disease, type 2 diabetes mellitus (DM) with diabetic neuropathy, and hypertension. A review of the care plan initiated on 8/10/2017	Y 000 Y 339	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. JM (Initials) **Y 339** **Corrective action for residents found to have been affected by this deficiency:** Resident #3's blood sugars have been within ordered perameters for the past four months, and the medical provider has reviewed the accucheck and insulin orders. **Corrective action for residents that may be affected by the deficiency:** Any resident with on accuchecks with ordered perameters may be affected when blood glucose levels are out of range, and the medical provider is to be notified of the change of condition. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were re-inserviced that blood glucose levels either low or high and outside of perameters is considered a change of condition, and the medical provider and resident and/or responsible party is to be notified. Audit tools and processes have been developed.	11/12/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jm CHD — TITLE: Administrator — (X6) DATE: 10/15/2021

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 _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Y 339	Continued From page 1 revealed the resident was at risk for hyper/hypoglycemia. The goal was that the resident would be free from any signs/symptoms of hyper/hypoglycemia. Interventions included accu check and to observe/document/report to MD (Medical Doctor) signs/symptoms of hypoglycemia and hyperglycemia. Review of the physician's orders revealed an order dated 09/24/2020 for accu check two times a day for DM and to call the MD/NP (Nurse Practitioner) if the blood sugar was <60 or >350. Review of the Medication Administration Report (MAR) for January 2021 revealed the resident's blood sugar was 405 on 1/11/2021 at 8:00 PM and 494 on 1/22/2021 at 8:00 PM. No blood sugar was documented for 1/27/2021 at 8:00 PM and 1/28/2021 at 5:00 AM. The MAR for February 2021 revealed the resident's blood sugar was 368 on 2/06/2021 at 8:00 PM and 354 on 2/26/2021 at 8:00 PM. A review of the MAR for June 2021 revealed the resident's blood sugar was 398 on 6/14/2021 at 8:00 PM. No blood sugar was documented for 6/18/2021 at 5:00 AM. Continued review of the clinical record did not reveal documentation that the MD/NP were notified of the blood sugars that were greater than 350. An interview was conducted with a Licensed Practical Nurse (LPN/staff #11) on 9/23/2021 at 09:10 AM. The LPN stated that when an accu check level is above 350 or below 60, the interventions implemented and physician notification should be documented in the clinical	Y 339	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GRANITE CREEK HEALTH & REHABILITATION CENTI	1045 SCOTT DRIVE PRESCOTT, AZ 86301

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Y 339	Continued From page 2 record. She further stated that the expectation is to follow the physician's orders as written. The LPN reviewed resident #3 clinical record and stated that there was no documentation that the physician was notified when the resident's blood sugar was greater than 350. The LPN stated the physician's order had not been followed regarding blood glucose levels and that the risk is that the provider was not aware of the resident's blood sugars that were greater than 350. The LPN also stated that no blood sugar levels documented did not follow the MD order or meet facility expectation. She stated that the risk of blood sugars not being performed as ordered could be hyperglycemia or hypoglycemia. An interview was conducted on 9/23/2021 at 10:18 AM with the Director of Nursing (DON/staff #10) with the Corporate Registered Nurse Clinical Resource in attendance (staff #100). The DON stated that the facility process and expectation is that physician orders and parameters will be followed as written. She stated that the nurses document the blood sugar results on the MAR. She stated that notification to the provider regarding blood sugar levels not meeting parameters would be documented in the nurse progress notes or a daily skilled nurse note. The DON reviewed the clinical record for resident #3 and stated that she did not see documentation that the provider had been notified as ordered when the blood sugar was greater than 300. She stated that the physician order was not followed. Staff #10 stated the risk would be the physician would not be aware of the resident's blood sugar levels that were greater than 350. The DON also stated that blood sugar levels not documented on the MAR did not follow the physician order or meet expectations status. She stated the risk could be hypo or hyper glycemia not being	Y 339		

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Y 339	Continued From page 3 identified. Review of the facility policy titled, Finger Stick Blood Sugars/Hypoglycemia/Hyperglycemia dated 01/2020, revealed all blood sugars out of range will be followed up with physician notification, this will be documented in Point Click Care (PCC). Document all finger blood sugar levels in the EMAR (electronic MAR) in PCC. If documenting follow-up blood sugar levels after interventions, document in PCC or under progress notes. The policy included to follow physician orders. Review of the facility policy titled, Injections, Insulin, revealed that it is the facility policy that insulin injections and blood glucose monitoring will be done following physician's orders.	Y 339		
Y1045	R9-10-410.B.4.c. Resident Rights R9-10-410.B. An administrator shall ensure that: R9-10-410.B.4. A resident or the resident's representative: R9-10-410.B.4.c. Except in an emergency, is informed of proposed alternatives to psychotropic medication or a surgical procedure and the associated risks and possible complications of the psychotropic medication or surgical procedure; This RULE is not met as evidenced by: Based on clinical record reviews, staff interviews, and facility policy, the facility failed to ensure that two residents (#10 and #5) and/or their representatives were informed of the associated	Y1045	**Y 1045** **Corrective action for residents found to have been affected by this deficiency:** Informed consent for psychotropic medication has been obtained for residents # 10 and #5. **Corrective action for residents that may be affected by the deficiency:** A full house audit has been completed for residents on any psychotropic medication to ensure all have informed consent for use.	11/12/21

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Y1045	Continued From page 4 risks and possible complications of psychotropic medications prior to the administration of the medications. Findings include: -Resident #10 was admitted to the facility on March 29, 2021 with diagnoses that included major depressive disorder, chronic pain, type 2 diabetes and ischemic cardiomyopathy. The quarterly Minimum Data Set (MDS) assessment dated July 6, 2021 revealed that the resident could not complete a Brief Interview for Mental Status (BIMS) due to not being able to be understood. Both the resident's short term and long term memory were assessed to be okay. The MDS further revealed that the resident had received an antidepressant medication daily in the 7-day look-back period of the assessment. Review of the care plan, revised August 29, 2021, revealed that the resident was receiving an antidepressant medication. An intervention for this focus area included that the resident and family were to be educated on the risks and benefits and side effects of taking the antidepressant medication. Review of the physician orders revealed an order dated August 30, 2021 for Prozac (an antidepressant medication and also a psychoactive medication) 20 milligrams (mg) for depression. Review of the resident's Medication Administration Records (MAR) for June through September 2021 revealed the Prozac was administered as ordered.	Y1045	**Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses have been re-inserviced regarding obtaining informed consent prior to administering any psychotropic medication, and to obtain the consent promptly when receiving the order. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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Y1045	Continued From page 5 Review of the clinical record revealed no evidence that the resident and/or the resident's family had been provided information about the risks and benefits of the antidepressant medication prior to receiving the medication. An interview was conducted on September 23, 2021 at 12:28 p.m. with the medical records supervisor (staff #56). She stated that she had reviewed the resident's clinical record and that there were no signed informed consents in the record for psychoactive medications. She stated that she was not aware of the reason that no consents were found in the record. On September 23, 2021 at 1:01 p. m. an interview was conducted with the Director of Nursing (DON/staff #10). She stated the medication informed consents are completed by admissions or by a nurse. She stated that there had been some staff turnover but she was unsure why this resident did not have an informed consent in the record. -Resident #5 was admitted to the facility on September 13, 2019 with diagnoses that included anxiety disorder and bipolar disorder. Review of the psychotropic medication care plan, dated September 2, 2021, revealed that the resident was receiving antipsychotic medication related to bipolar disorder as evidenced by mood disturbances. Interventions included to administer the medication as ordered and to educate the resident and the resident's family about the risks, benefits, and the side effects of the medication. Review of the annual MDS assessment dated September 21, 2021, revealed the resident scored a 12 on the BIMS indicating moderate	Y1045		

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Y1045	Continued From page 6 cognitive Impairment. The MDS included that the resident received antipsychotic medications daily during the 7-day look-back period of the assessment. A review of the physician's orders for September 3 through 24, 2021 revealed multiple orders for Risperdal (an antipsychotic/psychotropic medication) for bipolar disorder as evidenced by mood disorder. The dose of the medication changed several times and ranged from 0.25 mg to 1.0 mg. Review of the MAR for September 3 through 24, 2021 revealed the resident received the Risperdal as ordered. Review of the clinical record revealed no evidence that the resident and/or the resident's family had been informed of the risks and benefits of the antipsychotic medication Risperdal prior to receiving the medication. An interview was conducted with a Licensed Practical Nurse (LPN/staff #11) on September 23, 2021 at 8:40 a.m., who stated that the facility process is to obtain informed consents prior to administering psychotropic/antipsychotic medications. She further stated that when an antipsychotic medication is prescribed, the nurse would be responsible for obtaining the medication consent. She stated that the consent is completed on paper, and then given to medical records to scan into the resident's Electronic Medical Record (EMR). She stated that Risperdal is a psychotropic medication and would require a consent. She then reviewed the medical record and stated that the resident has been receiving Risperdal and has a current order for it. She further stated that she could not locate a consent	Y1045		

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Y1045	Continued From page 7 for Risperdal in the medical record. She also stated that after reviewing the MAR for September 2021, Risperdal had been administered without a consent. She also stated that this did not meet facility expectations or policy and the risk would be that the resident may not be educated on the risks and side effects of Risperdal. An interview was conducted on September 23, 2021 at 10:11 a.m. with the medical record supervisor (staff #56), who stated that the nurses are responsible to complete medication consents and then would give them to medical records to scan into the resident EMR. She also stated that she keeps the original consents in a file in her office for all residents. She reviewed the medical record and stated that there was no consent for Risperdal in the resident's EMR. She also stated that she did not have one in her office files. An interview was conducted with the DON (staff #10) on September 23, 2021 at 10:18 a.m., with a corporate clinical resource registered nurse (staff #100) in attendance. The DON stated the facility expectation regarding new physician orders for psychotropic/antipsychotic medications is to inform and educate the resident about the medication and to review the consent and obtain a signature. She further stated that if the resident agrees, they would then start administering the medication. The DON then stated that the completed consents are given to medical records to scan into the EMR. She reviewed the physician's orders in the EMR and stated that the resident has been receiving Risperdal, and that there should be a consent in the EMR for this medication. She further reviewed the medical record and stated that there was not a consent in the EMR for Risperdal.	Y1045		

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Y1045	Continued From page 8 An interview was conducted on September 23, 2021 at 11:07 a.m. with a LPN (staff #81), who stated that she is responsible for ensuring the psychotropic consents are completed when they receive a new order. She stated the process is to verify the order, request the medication from the pharmacy, then complete the medication consent with the resident. She stated that she would speak with the resident to obtain a signature on the consent form, then take the completed form to medical records to be scanned into the EMR. She further stated that she remembered being the nurse that completed the consent form for this resident. The LPN stated that she placed the consent in a basket in the nursing room, she looked in this room and in all the baskets and did not see the resident's Risperdal consent. She reviewed the resident's EMR and stated that she did not see the signed consent. The LPN was not able to present a signed consent or documentation that the resident had been educated and consented to Risperdal prior to administration. Review of the facility's psychoactive medication policy, revised May 2021, revealed that the policy of the facility is to maintain every resident's right to be free from the use of psychoactive medications. The policy further noted that the use of a psychoactive medication must first be explained to the resident, family member, or legal representative. The policy included that a consent is to be obtained either from the resident or responsible party if the resident is unable to give consent.	Y1045		
Y1077	R9-10-410.C.2. Resident Rights	Y1077		

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Y1077	Continued From page 9 R9-10-410.C. A resident has the following rights: R9-10-410.C.2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities; This RULE is not met as evidenced by: Based on an observation, clinical record reviews, facility documentation, interviews, and facility policies, the facility failed to ensure that two residents (#5 and #7) received treatment that supported their choices and abilities by failing to ensure they received consistent showers. Findings include: -Resident #5 was admitted to the facility on September 13, 2019, with diagnoses that included anxiety disorder, bipolar disorder, fibromyalgia, rheumatoid arthritis, and muscle weakness. Review of an Activity of Daily Living (ADL) care plan, dated September 14, 2019, revealed the resident had self-care deficits related to diagnoses of fibromyalgia and weakness. Interventions included the resident required staff participation with personal hygiene, and to provide a sponge bath when a shower cannot be tolerated. Review of the annual Minimum Data Set (MDS) assessment dated September 21, 2021 revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated that bathing did not occur during the 7-day look-back period of the	Y1077	**Y 1077** **Corrective action for residents found to have been affected by this deficiency:** Residents #5 and #7 both frequently refuse showers, and the Director of Nursing and Social Worker have met with each of these residents to ascertain reasons. The medical provider and responsible parties have been notified of the resident's choice to not take showers periodically, and the care plan has been updated. **Corrective action for residents that may be affected by the deficiency:** All residents could be affected. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses and CNAs have been re-inserviced on showers and shower documentation in the medical record, including documenting refusals. Audit tolls and audit processes have been developed. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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Y1077	Continued From page 10 assessment. Review of the facility's shower schedule, revealed the resident was to receive a shower every Tuesday and Friday. Review of bathing documentation revealed that the facility documented bathing in two locations, one was in the Electronic Medical Record (EMR) and the other was on shower sheets. Both were reviewed for July, August, and September 2021 and revealed multiple weeks where the resident either received one shower per week, refused one shower and did not receive another shower in a week, or received no showers per week. This included a stretch of three weeks where the resident received only one shower per week and two consecutive weeks in September that the resident did not receive a shower at all. During an interview conducted with the resident at 12:07 PM on September 20, 2021, she stated that she used to receive two showers per week, but that lately it had gone to just one per week. She stated receiving a shower depended on who was working and how many staff are available at the time. During the interview, the resident was observed to have hair that was not combed, had long fingernails on both hands, and was wearing a hospital type gown. The resident stated that she did not like her fingernails long, and that they were not being trimmed frequently. An interview was conducted on September 12, 2021 at 1:06 p.m. with a Licensed Practical Nurse (LPN/staff #11). She stated that residents receive showers two days a week and there is a shower schedule that is followed. She stated that when the Certified Nursing Assistants (CNAs) complete a resident shower, they also complete a shower	Y1077		

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Y1077	Continued From page 11 sheet. She said that when a resident refuses a shower, the CNA documents this on the shower sheet and informs the nurse. She further stated that CNAs will document showers in the EMR. She said this is true when showers are given and when showers are refused. She reviewed the EMR for showers and stated that there was no documentation of the resident receiving a shower after September 10, 2021. She then reviewed additional documentation in the medical record and stated the resident was missing other showers in August and September. She also stated the documentation included that the resident refused some of her showers. The LPN stated that the residents should have their fingernails trimmed at the time of the shower. An interview was conducted on September 21, 2021 at 1:35 p.m. with a CNA (staff #89), who stated the facility expectation is for the residents to receive showers twice a week, or more if there is a need for additional showers. She stated that there is a shower book at the nursing station with the residents' shower days by room number, and is divided between day and night shift. The CNA stated when a resident refuses or is out of the facility, they might not receive a shower twice that week, but they try to conduct the shower later in the day or on a different day. She further stated that showers are documented by the CNAs in the medical record, and also on a shower sheet. She stated the process is to give the completed shower sheets to the staffing coordinator (staff #89), who then forwards them to the Director of Nursing (DON). She reviewed the bathing/shower documentation from the EMR and stated there were several days where the resident did not receive a shower. An interview was conducted on September 21,	Y1077		

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Y1077	Continued From page 12 2021 at 1:57 p.m. with the staffing coordinator (staff #34), who stated that there is a shower schedule by room number and day, divided into day and night shifts. He stated that the facility expectation is for residents to receive showers twice a week. He stated that he receives the completed shower sheets, which he reviews. He stated that the shower sheets are signed by the nurses after the shower. He reviewed the shower sheets for the resident and stated the most current shower sheet for the resident was from September 10, 2021. He then reviewed the shower sheets for August 2021 and stated he could only find 5 shower sheets for that month. He reviewed the July 2021 shower sheets and stated he had completed forms for 4 days of that month. He further stated that this does not follow facility expectations. An interview was conducted on September 21, 2021 at 2:38 p.m. with the DON (staff #10), who stated that the facility expectation is for residents to receive two showers a week, following the shower schedule. She further stated that the showers would be documented by CNAs on the shower sheets, and in the EMR medical record. She reviewed the EMR and stated that no showers were given or refused from September 12 to 24, 2021, and this is not following facility policy. An interview was conducted on September 22, 2021 at 9:58 a.m. with the Corporate Clinical Resource (staff #100) who stated that she further reviewed the resident's medical records, shower sheets and found no other documentation regarding showers. She further stated that they had started education last night and today regarding shower documentation.	Y1077		

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Y1077	Continued From page 13 -Resident #7 was admitted to the facility on September 14, 2018 with diagnoses that included epilepsy, muscle weakness, major depressive disorder, and other secondary gout to the left ankle and foot. Review of the resident's ADL care plan dated September 14, 2018, revealed the resident had an ADL self-care performance deficit related to decreased active functional mobility, muscle weakness, difficulty walking, and risk of incontinent episodes. The resident required limited to extensive assistance of one to two staff for ADLs. The goal was for the resident to safely perform ADLs with assistance from 1 to 2 staff through the review date. Interventions included to explain all procedures/tasks to the resident before starting and praise all efforts of self-care. The quarterly MDS assessment dated May 24, 2021, revealed the resident had a BIMS score of 14, which indicated no cognitive impairment. The MDS identified that the resident required one-person assistance with bed mobility and transfer, and required set up assistance with hygiene. The MDS also indicated that the resident required one-person assistance with bathing. Review of the facility's shower schedule, revised July 2, 2021, revealed the resident was to receive showers on Tuesdays and Fridays. Review of bathing documentation revealed that the facility documented bathing in two locations, one was in the Electronic Medical Record (EMR) and the other was on shower sheets. Both were reviewed for July, August, and September 2021 and revealed multiple weeks where the resident did not receive two showers per week including a stretch in August where the resident did not	Y1077		

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Y1077	Continued From page 14 receive a shower at all from August 10 through 31. Review of the nursing notes from July 1 through September 22, 2021 revealed no evidence that the resident was provided a shower or the resident refused a shower on the dates that did not have a shower sheet or bathing documentation in the EMR. There were no notes to show that the resident received any additional showers. An interview with the resident was conducted on September 20, 2021 at 12:42 p.m. He stated that he does not receive showers regularly. He stated he thinks he does not receive his showers as scheduled because there are not enough staff to provide the showers. An interview was conducted with a CNA (staff #82) on September 21, 2021 at 1:58 p.m. She stated that showers are provided according to the shower schedule. She stated the facility has a shower book by the nursing station which includes the shower schedule as well as shower sheets. She said the showers are to be documented on the shower sheet as well as in the EMR. She stated if a resident refuses a shower, she will try to reschedule the shower but she still has to fill in the shower sheet and the resident has to sign the shower sheet. She stated she had not had issues with residents not receiving showers, but said sometimes the residents tell her that they have not received showers for many days. An interview was conducted with a CNA (staff #89) on September 21, 2021 at 2:28 p.m. She stated that showers are done twice per week and are document both in the EMR and on a shower	Y1077		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE CREEK HEALTH & REHABILITATION CENTE	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
Y1077	Continued From page 15 sheet that is signed by the CNA and the nurse. She said that after the sheet is signed, it goes to the staffing coordinator (staff #34) and then to the DON (staff #10). An interview was conducted with a CNA (staff #33) on September 22, 2021 at 12:57 p.m. She stated that the resident needs set-up help for showers but is able to shower himself. She said that the resident does not usually refuse showers but that she has been having issues charting showers in the EMR lately because it was not coming up easily. An interview was conducted with a LPN (staff #85) on September 22, 2021 at 1:34 p.m. She stated that showers are provided by the CNA and the CNA fills out the shower sheet. She stated the CNA then turns in the shower sheets to the nurse for review and both of them sign the sheet. She stated the shower sheet is then given to the staffing coordinator or the DON. She stated that this resident refuses showers sometimes and if a resident refuses a shower, the shower sheet is signed by the resident. She stated shower refusals are also documented in nursing notes in the resident's clinical record. An interview was conducted with the DON (staff #10) on September 22, 2021 at 2:08 p.m. She stated the facility has started in-servicing the staff to document showers in one place or location. She stated after a shower sheet is filled out, the staff hand the shower sheets to the staffing coordinator (staff #34) who reviews them and gives them to her. She said she also reviews them to ensure they are filled out correctly and completely. She stated that they are not reviewing them to ensure the showers are being provided as scheduled.	Y1077		

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Y1077	Continued From page 16 Review of the facility's ADL policy, revised July 2020, revealed that bathing will be offered at least twice per week and as needed per resident request. The policy also noted that ADL care provided will be documented accordingly. The facility's shower and bed bath policy, revised May 2021, revealed that showers and bed baths will be provided to residents in accordance with the resident's shower schedule. If a resident is unable to be showered on their scheduled day due to room changes or appointments, staff will attempt to reschedule and the shower or bed bath will be documented accordingly.	Y1077		
Y1235	R9-10-412.B.7. Nursing Services R9-10-412.B. A director of nursing shall ensure that: R9-10-412.B.7. An unnecessary drug is not administered to a resident. This RULE is not met as evidenced by: Based on clinical record review, interviews, and facility policy, the facility failed to ensure that one resident (#10) did not receive an unnecessary pain medication. Findings include: Resident #10 was admitted to the facility on March 29, 2021 with diagnoses that included major depressive disorder, chronic pain, type 2 diabetes, and hypertension.	Y1235	**Y 1235** **Corrective action for residents found to have been affected by this deficiency:** Resident #10 PRN pain medication orders, along with the resident's pain levels daily, have been reviewed with the medical provider. **Corrective action for residents that may be affected by the deficiency:** Any resident with multiple PRN pain medications could be affected. **Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses have been re-inserviced regarding PRN pain medications and PRN pain scales, and administering pain medication only according to the physician ordered perameters. Audit tools and audit processes have been developed.	11/12/21

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Y1235	Continued From page 17 Review of the physician's orders revealed an order dated March 29, 2021 for oxycodone/acetaminophen (pain medication that includes an opioid) tablet 10/325 milligrams (mg) 1 tablet by mouth every 4 hours as needed (prn) for pain of 4 to 10 on the pain scale. Review of the resident's pain care plan, dated March 30, 2021, revealed the resident had acute and chronic pain. An intervention included to administer pain medications according to the pain scale. The care plan was revised on August 29 to include that the resident was prescribed an opioid pain medication. The quarterly Minimum Data Set (MDS) assessment dated July 6, 2021 revealed that the resident could not complete a Brief Interview for Mental Status (BIMS) due to not being able to be understood. Both the resident's short term and long term memory were assessed to be okay. The assessment included that the resident received opioids daily during the 7-day lookback period. Review of the resident's Medication Administration Records (MAR) from June through September 2021 revealed that the medication was administered outside of the physician ordered parameters on several occasions when it was administered for pain levels below 4 out of 10. This included several times when the medication was given for a pain level of 0 out of 10. Review of the nursing notes revealed no indication as to why the medication was given outside of the ordered parameters. An interview was conducted on September 23,	Y1235	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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Y1235	Continued From page 18 2021 at 10:50 a.m. with a Licensed Practical Nurse (LPN/staff #11). She stated that when administering a medication, she reviews the order and the MAR. She said that if the order includes parameters for administration, such as a specific pain level, she would check the pain scale herself and then document this information in the MAR. She said that the pain level would determine if the pain medication is given. She said she would follow the parameters on the order to ensure she gives the right medication. She said that if a pain medication is given outside of the ordered parameter, it may be because the nurse who administered the medication did not fully know what they were doing because the order should be specific. She said that if this occurs, it could cause unwanted and unexpected side effects due to the unnecessary administration of the pain medication. She reviewed the resident's September 2021 MAR and said that there were several instances where the prn pain medication was given outside of the ordered parameters. She said that this did not make any sense and she was not sure why this happened. She said that this was especially true when the pain medication was given for a pain level of 0 since this would mean that the resident did not have pain and therefore would not need prn pain medication. On September 23, 2021 at 11:52 a.m., an interview was conducted with the clinical resource nurse (staff #100), the Director of Nursing (DON/staff #10) and the DON in training (staff #110). Staff #100 stated that when an order is received, if it includes parameters, staff are to follow them. She said that nurses were expected to offer prn medications if needed and if an order is in place. She further stated that if a prn medication is needed, the nurse that	Y1235		

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Y1235	Continued From page 19 administered the medication was expected to ensure the pain level is correctly documented in the resident's MAR. The DON stated that the pain level documented on the MAR is the original pain level that the resident stated and the follow up pain scale number should be documented in the nursing notes. The 3 staff members reviewed the September MAR and agreed that there were at least 2 instances that the prn pain medication was given outside the parameters. Review of the facility's medication administration policy, dated August 2020, revealed that medications must be administered in accordance with the written orders of the attending physician. The policy stated that when prn medications are administered, the nurse must record the justification/ reason the medication was given, the date and time the medication was administered, and any results achieved from administering the medication.	Y1235		
Y2137	R9-10-421.B.3.a. Medication Services R9-10-421.B. An administrator shall ensure that: R9-10-421.B.3. A medication administered to a resident: R9-10-421.B.3.a. Is administered in compliance with an order, and This RULE is not met as evidenced by: Based on clinical record review, interviews, and facility policy, the facility failed to ensure that two	Y2137	**Y 2137** **Corrective action for residents found to have been affected by this deficiency:** Residents #10 and #3 blood pressures and hypertensive medication orders for the past two months have been reviewed with the attending physician **Corrective action for residents that may be affected by the deficiency:-** Any resident with blood pressure perameters and PRN blood pressure medication orders may be affected. A full house audit of all residents with these orders, along with their blood pressure for the past two months have been reviewed with the medical provider to ensure PRN antihypertensive medications orders are appropriate.	11/12/21

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y2137	Continued From page 20 residents (#10 and #3) received blood pressure medications per physician's orders. Findings include: -Resident #10 was admitted to the facility on March 29, 2021 with diagnoses that included major depressive disorder, chronic pain, type 2 diabetes, and hypertension. Review of the physician's orders revealed an order dated March 29, 2021, for Catapres (a blood pressure medication) 0.1 mg tablet by mouth every 6 hours as needed (prn) for systolic blood pressure greater than 160 millimeters of mercury (mmHg). The quarterly Minimum Data Set (MDS) assessment dated July 6, 2021 revealed that the resident could not complete a Brief Interview for Mental Status (BIMS) due to not being able to be understood. Both the resident's short term and long term memory were assessed to be okay. The resident's hypertension (high blood pressure) care plan, revised August 29, 2021, revealed the resident needed medications to treat hypertension. An intervention included that the medications would be administered as ordered. Review of the resident's vital sign summary and the MARs from June through September 2021 revealed multiple times each month where the resident's systolic blood pressure was greater than 160 mmHg. Further review of the MARs from June through September 2021 revealed that the blood pressure medication was not given when the resident's systolic blood pressure was above 160 mmHg.	Y2137	**Measures that will be put into place to ensure that this deficiency does not recur:** Licensed nurses were re-inserviced regarding PRN blood pressure medications and following ordered perameters for administering. Audit tools and audit processes were developed. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Random audits will be done twice a week for two weeks, then weekly for two weeks, then monthly for two months. Analysis and findings will be reported to the QAA Committee monthly. Responsible: Director of Nursing	11/12/21

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Y2137	Continued From page 21 On September 23, 2021 at 10:38 a.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #8). She stated that if medications are ordered prn, the nurse is expected to check the MAR for the parameters and dosage and compare the vital sign to the parameters listed in the order. If the medication is to be administered per the parameters, she stated that should be documented along with the vital sign or reason for administering the medication. She stated that she also documents this information in a nursing note as well. An interview was conducted on September 23, 2021 at 10:50 a.m. with a LPN (staff #11). She stated that when giving medication, she looks at the MAR for the resident and reviews the medications. She stated that if a medication has blood pressure parameters, she would check the blood pressure herself and she would document the information in the MAR. She said that if a medication is ordered as prn, the order on the MAR includes a section to enter the vital signs needed to give the medication. This should be filled in anytime the medication is given. On September 23, 2021 at 11:52 a.m., an interview was conducted with the clinical resource nurse (staff #100), the Director of Nursing (DON/staff #10) and the DON in training (staff #110). Staff #100 stated that when an order is received, if it includes parameters, staff are to follow them. She said that nurses were expected to offer prn medications if needed and if an order is in place. Staff #100 stated that all vitals are documented, especially for PRN medications. Staff #100 stated that vitals can be taken by the nurse or a Certified Nursing Assistant (CNA).	Y2137		

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Y2137	Continued From page 22 An interview was conducted on September 23, 2021 at 1:01 p.m. with the DON (staff #10). She stated that she had no idea why the blood pressure medication was not given when the resident's systolic blood pressure was above 160 mmHg since this was the what the order said. She said that this does not meet her expectation of medication administration in the facility. -Resident #3 was readmitted to the facility on November 8, 2020 with diagnoses that included atherosclerotic heart disease, chronic kidney disease, type 2 Diabetes Mellitus (DM) with diabetic neuropathy, and hypertension. A physician's order dated May 25, 2020 was for clonidine 0.1 mg every 8 hours prn for systolic blood pressure over 170 mmHg. Review of the resident's blood pressure care plan, dated June 21, 2021, revealed the resident had hypertension. Interventions included to take the resident's blood pressure as ordered and to give blood pressure medications as ordered. Review of the MARs for January through September 2021 revealed that the clonidine was not administered when the resident's systolic blood pressure was over 170 mmHg on several occasions. This occurred every month except for March 2021. It only occurred once in June and August 2021, but occurred multiple times in January, February, April, May, July and September. Further review of the MAR revealed that on June 18, 2021 the clonidine was administered for a systolic blood pressure of 151 mmHg during the day and then again for a systolic blood pressure of 147 mmHg at night.	Y2137		

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Y2137	Continued From page 23 An Interview was conducted with a LPN (staff #11) on September 23, 2021 at 9:10 a.m., who stated the facility expectation is to follow physician orders as written. She reviewed the physician's order for the clonidine and stated that if the systolic blood pressure is above 170 mmHg, the medication should be given. She reviewed the MARs for January through September 2021 and stated that the prn clonidine should have been administered on the days that the systolic blood pressure was documented as being over 170 mmHg. She stated that clonidine was administered on June 18, 2021 on both the day and night shifts, but it was not following physician's orders, as the systolic blood pressure was below 170 mmHg on both occasions. She stated that after review of the MARs from January through September 2021, that clonidine had not been administered following physician's orders, and the risk could be worsening of the resident's heart condition. An interview was conducted on September 23, 2021 at 10:18 a.m. with the DON (staff #10), with the Corporate Clinical Resource in attendance (staff #100). The DON stated that it is the facility expectation to administer medications as written in the physician order. She reviewed the medical record and stated that there was a current physician's order for clonidine every 8 hours prn for a systolic blood pressure greater than 170 mmHg. She stated that her expectation is that staff follow the physicians' orders as written. She reviewed the MAR from January to September 2021 and stated that the clonidine had not been given several times when the resident's systolic blood pressure has been greater than 170 mmHg. She further stated that on June 18, 2021, the clonidine had been given for a systolic blood	Y2137		

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Y2137	Continued From page 24 pressure below 170 mmHg, which was not following physician's orders. The DON stated that she will start a process for monitoring medication administration and staff education. Review of the facility's medication administration policy, dated August 2020, revealed that medications must be administered in accordance with the written orders of the attending physician. The policy stated that when prn medications are administered, the nurse must record the justification/reason the medication was given, the date and time the medication was administered, and any results achieved from administering the medication.	Y2137		

ADHS
LICENSING

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: September 17, 2021

Survey Event ID: A3PR11

Inspector/Team Coordinator: Lisa Bashford

Accompanied By: Paul Rehman, Inka Rajbhandari, Travis Beach, Lisa Andrin-Mazur

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, 7878 N. 16th St., Suite 235 Phoenix AZ 85020 (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: 9/20/21

☐ 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: Lisa Bashford — Date: 9/20/21

☒ Copy left with Administrator/Director/Agency Representative

QUALITY RATING CERTIFICATE

Arizona Department of Health Services

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

Issued To: Granite Creek Health & Rehabilitation Center

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	22	3
II. Resident Rights	24	1
III. Administration	25	0
IV. Environment and Infection Control	15	0
V. Food Services	10	0
TOTAL CRITERIA MET	96	4

QUALITY PERFORMANCE SCALE	
"A"	
"B"	
"C"	
"D"	
"A": 90 to 100 points "B": 80 to 89 points "C": 70 to 79 points "D": 69 or fewer points	

License Effective:

From: To:

Issued: 10-7-21

Number: NCI-2788

Recommended By

Issued By Assistant Director

Quality Rating Evaluation

Facility: Phone:

Address:

Survey Date: Contact Person:

Nursing Services:

Criteria:	Pts.	Criteria Met? 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	13	2
The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.	5	5	0
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	4	1

Points Yes 22

Points No 3

Comments:

Resident Rights:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution is implementing a system that ensures a resident's privacy needs are met.	10	10	0
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	10	0
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	4	1

Points Yes 24

Points No 1

Comments:

Administration:

Criteria:	Pts.	Criteria Met? 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	10	0
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	5	0
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	5	0
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	1	0
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	1	0
The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.	2	2	0
The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.	1	1	0

Points Yes 25

Points No 0

Comments:

Environment and Infection Control:

Criteria:	Pts.	Criteria Met? 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	5	0
The nursing care institution establishes and maintains a pest control program.	1	1	0
The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.	1	1	0
The nursing care institution ensures orientation to the disaster plan for each staff member is completed within the first scheduled week of employment.	1	1	0
The nursing care institution maintains a clean and sanitary environment.	1	1	0
The nursing care institution is implementing a system to prevent and control infection.	5	5	0
An employee washes hands after each direct resident contact or where hand washing is indicated to prevent the spread of infection.	1	1	0

Points Yes 15

Points No 0

Comments:

Food Services:

Criteria:	Pts.	Criteria Met? 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	1	0
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	3	0
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	2	0
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	2	0
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	1	0
The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.	1	1	0

Points Yes 10

Points No 0

Comments: