



# QUALITY RATING CERTIFICATE

## ARIZONA DEPARTMENT OF HEALTH SERVICES NURSING CARE INSTITUTION



Issued To

Watson Woods Healthcare, Inc, dba  
Granite Creek Health & Rehabilitation Center  
1045 Scott Drive  
Prescott, Arizona 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	25	0
II. Resident Rights	25	0
III. Administration	25	0
IV. Environment and Infection Control	10	5
V. Food Services	10	0
TOTAL CRITERIA MET	95	5

QUALITY PERFORMANCE SCALE	
"A" Excellent	X
"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: 01/26/2017

To: 12/31/2017

Issued: 03/16/2017

Number: NCL-387

Recommended By

*Diane Eckles*

Issued By

*Cynthia*  
Interim Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

March 15, 2017

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

Dear Mr. Curran:

Enclosed is the **State Form: Revisit Report** form which indicates that the following deficiencies have been corrected on March 6, 2017. A copy will be filed in your public file.

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

Sincerely,

*B Hernandez*

Belinda Hernandez  
CSR4/Licensing Certification Specialist

\bh

Enclosure

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

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

W | [azhealth.gov](http://azhealth.gov)

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# STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER NCI-2728	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 3/6/2017
NAME OF FACILITY GRANITE CREEK HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1045 SCOTT DRIVE PRESCOTT, AZ 86301	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Y0339	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # R9-10-403.C.2.b.	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/05/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) DA	DATE 3/6/17	SIGNATURE OF SURVEYOR Dol Coleman	DATE 3/6/17
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/26/2017		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		



# ARIZONA DEPARTMENT OF HEALTH SERVICES

## LICENSING

Receipt of Notice Presumed 02/07/2017 via email

February 7, 2017

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

Dear Mr Monks:

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

Enclosed is a statement of **STATE** deficiencies noted during the inspection of your facility on January 26, 2017. 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:

- o 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;
- o How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- o What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- o 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.
- o 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 **February 17, 2017**. You must include all pages of the Statement of Deficiencies when submitting your PoC. **Plans of correction sent by fax will not be accepted.** Please retain a copy for your files. If the plan of correction is not received by this Office on or before this date, state enforcement action may be taken.

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

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

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Granite Creek Health & Rehabilitation Center  
February 7, 2017  
Page Two

**Informal Dispute Resolution**

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

Sincerely,

*Diane Eckles*

Diane Eckles  
Bureau Chief

DE\bh

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

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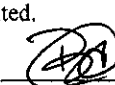
150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247    P | 602-364-2690    F | 602-324-0993  
W | [azhealth.gov](http://azhealth.gov)

*Health and Wellness for all Arizonans*

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  01/26/2017
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NAME OF PROVIDER OR SUPPLIER  GRANITE CREEK HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1045 SCOTT DRIVE PRESCOTT, AZ 86301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments  The State compliance survey was conducted on January 23, through 26, 2017, in conjunction with the following Complaints: #'s AZ00134209, AZ00139445 and AZ00134372. The following deficiency was cited:	RECEIVED Arizona Department of Health Division of Public Health Licensing Services FEB 16 2017 Reception Desk 150 N. 18th Ave #400 Phoenix, AZ 85007	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 339	R9-10-403.C.2.b. Administration  R9-10-403.C. An administrator shall ensure that:  R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that:  R9-10-403.C.2.b. Cover the provision of physical health services and behavioral health services;  This RULE is not met as evidenced by: Based on observation, staff interviews and policy review, the facility failed to implement physical health services policy, by failing to ensure infection control practices were followed during medication administration.  Findings include:  During a resident interview conducted on January 24, 2017, a LPN (Licensed Practical Nurse/staff #87) was observed to enter the resident's room and prepare to administer medications to the resident. Staff #87 had a plastic medicine cup		<u>Y339</u>  <u>Corrective action for residents found to have been affected by this deficiency:</u>  Licensed nurse staff #87 was immediately re-inserviced regarding medication administration techniques, including not touching medication with bare hands, for this affected resident  <u>Corrective action for residents that may be affected by the deficiency:</u>  Any resident needing medication administered in applesauce by licensed nurse staff #87 could be potentially affected. Licensed nurse staff #87 was immediately re-inserviced regarding medication administration techniques, including not touching medication with bare hands at any time.	3-5-2017

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

STATE FORM

5899

QCE011

TITLE

(X6) DATE

If continuation sheet 1 of 2

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NCI-2728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  01/26/2017
NAME OF PROVIDER OR SUPPLIER  GRANITE CREEK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1045 SCOTT DRIVE PRESCOTT, AZ 86301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 339	<p>Continued From page 1</p> <p>with applesauce in it, and a paper cup with several medications inside. Staff #87 placed applesauce on a teaspoon and then, with her bare fingers, she picked up two medications from the paper medication cup and placed them on the teaspoon of applesauce. Staff #87 then repeated this same process two more times.</p> <p>An interview was conducted on January 25, 2017 at 8:15 a.m., with the Director of Nursing (staff #129). Staff #129 stated that the LPN should never have touched the resident's pills with her bare hands, because hands are never clean. She stated the LPN should have used the spoon to scoop up the pills and then put them into the applesauce.</p> <p>A facility policy titled, General Dose Preparation and Medication Administration included the following: 3.4 Facility staff should not touch the medication when opening a bottle or unit dose package.</p>	Y 339	<p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Licensed nurses were re-inserviced regarding medication administration techniques policy and procedures, including not touching medication with bare hands at any time, on 2/8/17 and 2/11/17. Med pass observations were again completed on licensed nurses.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Random medication pass observations will be done weekly, and findings will be reported to the QAA Committee monthly.</p>	3-5-2017	



**ARIZONA DEPARTMENT OF HEALTH SERVICES  
DIVISION OF LICENSING SERVICES  
NOTICE OF INSPECTION RIGHTS**

Facility/Agency Name: Granite Creek Health and Rehabilitation Center

Address: 1045 Scott Drive

City: Prescott

Zip: 86301

Fac. I.D.#:  
LTC0057

License #:  
NCI-2728

Medi. #:  
035131

Date of Inspection:  
Jan. 23, 2017

Inspector/Team Coordinator: Desiree Gasiorowski

Accompanied By: J. Lapour, J. Castro, L. Wyllie

**OFFICE OF LONG TERM CARE LICENSING**

This inspection is conducted under the authority of:

1. Arizona Revised Statutes Title 36, Chapters 1 and 4, and Arizona Administrative Code, 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 Arizona Revised Statutes and Arizona Administrative Code.
  - ☒ Conduct a complaint investigation.
3. Application and License Fees are charged. There is no fee for the 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 formally notifying you of the findings will be provided. You will be afforded an opportunity to submit a Plan of Correction unless the Department is considering enforcement against the license. If the visit was a complaint investigation, a redacted copy of the investigation report, when completed, is available to you upon request.

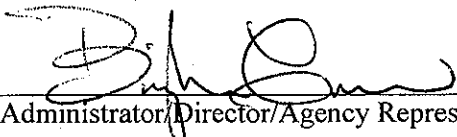




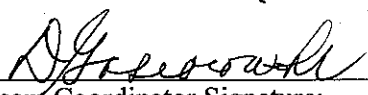
ARIZONA DEPARTMENT OF HEALTH SERVICES  
DIVISION OF LICENSING SERVICES  
NOTICE OF INSPECTION RIGHTS

8. You have an opportunity to dispute any findings of non-compliance through an Informal Dispute Resolution (IDR). To refute a deficiency listed on the Statement of Deficiencies, send a written request on a document separate from the Plan of Correction within fourteen days of receipt. The Plan of Correction must include the plan to correct the disputed deficiency. The IDR must pertain only to the accuracy of the findings and cannot refute the professional judgment of the Department's staff regarding the level, extent, scope, or severity of the deficiency. Indicate each specific deficiency being refuted and an explanation of why the deficiency is being refuted. Documentation must be included which shows the facility was in compliance at the time of the inspection. The management team will review the information and documentation provided and notify you of the Department's decision.
9. If you have questions regarding this inspection, you may contact the Office of Long Term Care at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3245, Phone: (602) 364-2690, FAX: (602) 364-4765. If you have any issues that you cannot resolve with the program or the Division, you may contact the Office of Ombudsman-Citizens Aide, 3737 N. 7<sup>th</sup> St., Suite 209, Phoenix, AZ 85014 (602) 277-7292.
10. Your Administrative hearing rights are found at A.R.S. §41-1092. If you need a copy of this statute, please contact our office.

Upon entry to the premises for this inspection, the inspector(s) presented photo identification indicating that they are Arizona Department of Health Services 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 Arizona Department of Health Services representative(s) may proceed with the inspection:

 1/23/17  
Administrator/Director/Agency Representative Signature Date:

- ☐ Administrator/Director/Agency Representative refused to sign this form.  
☐ Administrator/Director/Agency Representative or authorized on-site representative is not present.

 1/23/17  
Inspector/Team Coordinator Signature: Date:

- ☒ Copy left with Administrator/Director/Agency Representative

12.26.17  
1.26.17  
57  
LTC

# QUALITY RATING CERTIFICATE

## ARIZONA DEPARTMENT OF HEALTH SERVICES NURSING CARE INSTITUTION

Issued To: *Granite Creek*

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

COMPONENTS	CRITERIA MET	
	Yes	No
I. Nursing Services	25	
II. Resident Rights	25	
III. Administration	25	
IV. Environment and Infection Control	10	5
V. Food Services	10	
<b>TOTAL CRITERIA MET</b>	<b>95</b>	<b>5</b>

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:

Recommended By

Number: NCI-

Issued By

Assistant Director



## Quality Rating Evaluation

Facility:

Phone:

Address:

Survey Date:

Contact Person:

### Nursing Services:

Criteria: Criteria Met?  
Pts. YES NO

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

Points Yes 25

Points No \_\_\_\_\_

Comments:

**Resident Rights:**

Criteria:

Criteria Met?  
Pts. YES NO

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

Points Yes 25

Points No \_\_\_\_\_

Comments:

**Administration:**

Criteria:

Criteria Met?  
Pts. YES NO

The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last survey or other survey or complaint investigation conducted between the last survey and the current survey.	10	✓	
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	/	
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	/	
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	/	
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	/	
The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.	2	/	
The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.	1	/	

Points Yes 25

Points No \_\_\_\_\_

Comments:

**Environment and Infection Control:**

Criteria:

Criteria Met?  
Pts. YES NO

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

Points Yes 10Points No 5

Comments:

**Food Services:**

Criteria:


Criteria Met?  
Pts. YES NO

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

Points Yes 10

Points No \_\_\_\_\_

Comments:

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 86329  Prescott Valley Office: 928-533-1015 3212 N Windsong Drive Prescott Valley, AZ 86314
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## Foodservice Establishment Inspection Report

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

<b>Inspection Information</b>		
Inspection Type Routine	Inspection Date November 08, 2016	Total Time Spent

<b>Smoke Free Arizona Act</b>	
Compliant Yes	Evidence of Non-Compliance

<b>Equipment Temperatures</b>	
Description	Temperature (Fahrenheit)
COLD STORAGE W/I	
COLD STORAGE FREEZER W/I	

<b>Food Temperatures</b>	
Description	Temperature (Fahrenheit)
butter	138
cheese	38
turkey	38
yogurt	38

<b>Warewashing Information</b>					
Machine Name	Sanitization Method	Thermo Label	PPM	Sanitizer Name	Sanitizer Type
3-Comp Pro Clean Dishmachine Sani Buckets	manual Manual Manual		150 bleach		

<b>Food Safety</b>	
Certified Manager Yes	Food Safety Plan In Place Yes
Number Of Food Worker Cards 8	Number of Employees 8

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

--



**Observed Priority Violations**

Total # 0

Repeated # 0

**Observed Priority Foundation Violations**

Total # 0

Repeated # 0

**Observed Core Violations**

Total # 0

Repeated # 0

**Comments**

No violations noted.

**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



Sanitarian



William Blankemeier

**Prescott Fire Department**  
1700 Iron Springs Rd.

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

Date Inspected: 8/11/16

A D  N	Business Name: <u>Granite Creek Health Rehab</u>	Resp. Station: _____	Zone: _____	District: _____
	Address: <u>1045 Scott Drive</u>	Suite/Apt: _____		Zip: _____
	Business Phone: <u>928-778-9603</u>	Fax: _____		
	Vacant Suite _____	Vacant Bldg _____	New Business _____	Business Relocation from: _____

C O N T A C T S	Prop Owner Name: _____		Prop Owner Add: _____	
	Prop Owner City: _____		Prop Owner State: _____	
	Prop Owner Zip: _____			
	Owner Ph1: _____	Owner Ph2: _____	Owner Ph3: _____	
	Bus Owner Name: <u>EAISON</u>		Bus Owner Add: <u>MISSION VILLO 2701 Puerta Real</u>	
	Bus Owner City: <u>2701 Puerta Real</u>		Bus Owner State: <u>CA</u>	
	Bus Owner Zip: _____			
	Owner Ph1: _____		Owner Ph2: _____	
Mailing Name: _____		Mailing Address: _____		
City: _____		State: _____		
Zip: _____				
RP1: <u>BIGLEY CURAN</u>		Ph 1: <u>480-302-1521</u>	Ph 2: _____	Key Holder: <u>X</u> TP: _____
RP2: <u>SHAWN HELGESON</u>		Ph 1: <u>928-202-1531</u>	Ph 2: _____	Key Holder: _____ TP: _____
Add'l Contact Types: Manager [M] Business Owner [B] Prop Owner [P] Resp Party [RP] Resident [R] Contact [C] Other [O]				

P R E P L A N	Prop Use: <u>R</u>	Mixed Prop: _____	Complex: <u>1</u>	Building Status: _____	Building Class: _____
	Business Sq. Ft.: <u>15,000</u>	Stories Above: _____	Stories Below: _____	AED: _____	
	Detectors: _____ Detector Type: _____ Description: _____				
	Auto Extinguishing Sys: _____ Desc: <u>Wet Sprinkler</u> Sprinkler Sys Pressure (SPR): _____ Top: <u>75</u> Bottom: <u>70</u>				
	Sprinkler Riser Location (RISR): <u>Admin Hallway</u>				
	Fire Alarm Monitor Co. (ALRM): <u>CBS</u>				
	FACP Location (ALRL): <u>Center near Nursing Station</u>				
	Knox Box Location (KEYB): <u>On beam north of main Entrance</u>				
Fire Dept Connection Location (FDCN): <u>Remote NE corner of building</u>					

Fire Ext Tag DT: <u>6/16</u>	Sprink Tag DT: <u>7/16</u>	Fire Alm Tag DT: <u>4/16</u>	Keys Test DT: _____	Hood/Booth Tag DT: <u>4/16</u>
<input type="checkbox"/> Detectors	<input type="checkbox"/> FID Connection	<input type="checkbox"/> Gate - Keys Req	<input checked="" type="checkbox"/> Guards	<input type="checkbox"/> Hood System
<input type="checkbox"/> Dogs	<input type="checkbox"/> Fire Alarm Sys	<input type="checkbox"/> Gate - No Keys	<input type="checkbox"/> HazMat	<input type="checkbox"/> Knox Box
			<input type="checkbox"/> Standpipe	

Fire Code Section	THE FOLLOWING VIOLATIONS OF THE INTERNATIONAL FIRE CODE SHALL BE CORRECTED IMMEDIATELY	Date Corrected
	<u>Need key to front door</u>	
	<u>Emergency light out - Kitchen - Hallway 200</u>	

Reinspection Date: <u>8/25/16 @ 10:00</u>	ReCheck By: _____	Date: _____	ReCheck By: _____	Date: _____	ReCheck By: _____	Date: _____	Legal Action: _____
Received By: <u>[Signature]</u>	Inspector: <u>BZD 480-797-7006</u>			Station: _____	Shift: _____	Stn. Shift Inspecting: _____	

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

