

PROPERTY OF THE  
**ARIZONA DEPARTMENT OF HEALTH SERVICES**

653

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


This facility is licensed to operate as a **NURSING CARE INSTITUTION**

**Total Capacity: 128**


**From: July 1, 2017**

**To: June 30, 2018**

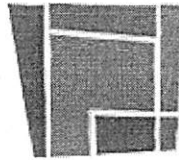
**Issued: April 18, 2017**

  
Recommended By: Diane Eckles, Bureau Chief

**License: NCI-2728**

  
Issued By: Colby Bower, Assistant Director

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION  
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED  
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

April 18, 2017

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

Dear Mr. Curran:

Enclosed is Nursing Care Institution license number Nci-2728, which authorizes your facility to operate 128 beds. In accordance with A.R.S. § 36-407(C), this license is only valid for the location indicated on the license. Please note the expiration date on your license.

Please be advised that A.R.S. § 36-425(A) requires this license to be conspicuously posted in the reception area of your facility. In addition, A.R.S. § 36-422(D) requires the Department to be notified of a change of ownership at least thirty (30) days prior to the effective date.

The Department has also completed an administrative completeness review of the renewal application and documents you submitted and determined that the application and documents are administratively complete and in compliance with licensing requirements.

Should you have any questions or concerns, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

A handwritten signature in cursive script, reading "Diane Eckles".

Diane Eckles  
Bureau Chief

DEib

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)

*Health and Wellness for all Arizonans*

LTC Beds HPP  
57 128 2155

7.1.17  
6.30.18



**RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION**  
**ARIZONA DEPARTMENT OF HEALTH SERVICES**  
**PUBLIC HEALTH LICENSING SERVICES – BUREAU OF LONG TERM CARE FACILITIES LICENSING**

In accordance with A.R.S. §41-1030  
B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.  
D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.  
E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.  
F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

**I. HEALTH CARE INSTITUTION INFORMATION**

Name of Health Care Institution: <b>GRANITE CREEK HEALTH &amp; REHABILITATION CENTER</b>		License No. <b>NCI-2728</b>							
Mailing Address: <b>1045 SCOTT DRIVE</b>									
City: <b>PRESCOTT</b>	State: <b>AZ</b>	Zip Code: <b>86301</b>							
Phone No. <b>(928) 778-9603</b>	Fax No. <b>(928) 778-5909</b>	E-mail: <b>renewals@EnsignServices.net</b>							
Class: <b>Nursing Care Institution</b>									
What is the health care institution's scope of service:  <b>Skilled Nursing Facility</b>									
Health care institution's days and hours of operation: <table border="0"><tr><td>Sun 24</td><td>Mon 24</td><td>Tues 24</td><td>Wed 24</td><td>Thurs 24</td><td>Fri 24</td><td>Sat 24</td></tr></table>			Sun 24	Mon 24	Tues 24	Wed 24	Thurs 24	Fri 24	Sat 24
Sun 24	Mon 24	Tues 24	Wed 24	Thurs 24	Fri 24	Sat 24			
Is health care institution accredited? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
Name of accrediting organization (must be from a nationally recognized organization):									
Is health care institution requesting certification under Title XIX of the Social Security Act? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									



## RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF LONG TERM CARE FACILITIES LICENSING

### II. OWNER INFORMATION

Owner's Name: WATSON WOODS HEALTHCARE, INC.

Street Address: 27101 Puerta Real Ste 450

City: Mission Viejo

State: CA

Zip Code: 92691

Phone No. (949) 487-9500

Fax No. (949) 540-3007

The owner is a (select one):

☐ Sole proprietorship

☒ Corporation

☐ Partnership

☐ Limited liability partnership

☐ Limited liability company

☐ Governmental agency

If the owner is a partnership or a limited liability partnership, the name of each partner;

If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;

If the owner is a corporation, the name and title of each corporate officer; or

If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency:

Name: John Albrechtsen

Title: President

Name: Beverly Wittekind

Title: Secretary

Name: Soon Burnam

Title: Secretary

Has the owner or any person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked, or suspended since the previous license application was submitted?

☐ YES ☒ NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license:



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Has the owner or any person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked, or suspended since the previous license application was submitted?

☐ YES ☒ NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension:

The name and address of the licensing agency that denied, revoked, or suspended the license or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? ☒ YES ☐ NO

### III. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: National Registered Agents, Inc.

Title: Statutory Agent

Street Address: 3800 N Central Avenue, Suite 460

City: Phoenix

State: AZ

Zip Code: 85012

Phone No. (602) 248-1145

### IV. GOVERNING AUTHORITY

Name: Watson Woods Healthcare, Inc.

Street Address: 27101 Puerta Real, Ste. 450

City: Phoenix

State: CA

Zip Code: 92691



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### V. CHIEF ADMINISTRATIVE OFFICER

Name: Brigham Curran

Title: Administrator

Highest Educational Degree: BA

Work experience related to the health care institution class or subclass related to licensing requested:

Previous experience includes AIT, current position as administrator.

### VI. SIGNATURES

1. If the applicant is an individual, the owner of the health care institution.
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.
3. If the applicant is a governmental agency, the head of the governmental agency.

Beverly Wittekind

Signature

Secretary

Title

Soon Burnam

Signature

Treasurer

Title

### VII. ADDITIONAL DOCUMENTATION

If the health care institution is located in a leased facility, submit a copy of the lease showing the rights and

responsibilities of the parties and exclusive rights of possession of the leased facility. ☒ YES ☐ NO