STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Creek Health & Rehabilitation Center	1045 Scott Drive Prescott, AZ 86301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, resident and staff interviews, and review of facility documentation and policy, the facility failed to ensure that medication was available for administration as ordered by the physician for one resident (#1). The deficient practice could result in the resident not receiving the needed medication. Findings include: Resident #1 was admitted on [DATE] with diagnoses of other seizures, hypertension, and neuropathy. A hospital progress note dated 5/21/2024 revealed that the resident had a history of myoclonic seizures; and, had tried Keppra (anti-seizure) in the past but could not tolerate this. The hospital clinical summary dated 5/23/2024 included that the resident had a diagnosis of seizure disorder. It also included to continue clonazepam 1 mg by mouth once a day at bedtime. A physician order dated 5/23/2024 included for clonazepam 1 mg at bedtime for anxiety AEB (as evidenced by) restlessness. The facility medication administration record (MAR) for 5/23/2024 revealed that clonazepam was marked as 7 which indicated to see Other/see nurse notes. The electronic MAR progress note timestamped 5/24/2024 at 1:38 a.m. indicated that clonazepam was not available. It also included that the pharmacy was contacted and the expected delivery date was 05/24/2024. The MDS (Minimum Data Set) note dated 5/24/2024 revealed that the resident was alert and oriented x4, had clear speech and was able to make self-understood. The Leaving the Facility Against Medical Advice form was signed by resident #1 and dated 5/24/2024. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Creek Health & Rehabilitation Center	1045 Scott Drive Prescott, AZ 86301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with resident #1 conducted on 6/24/2024, the resident stated that she did not get her medications at 10:30 p.m. on 5/23/2024 during medication pass; and that, she had to wait. The resident stated that when she received her medications on 5/23/2024, her seizure medication, clonazepam, was missing and she ended up having a seizure. She stated that she ultimately left the facility AMA on 5/24/2024 after staying less than 24 hours. In an interview with a licensed practical nurse (LPN/staff #45) conducted on 6/24/2024 at 4:15 p.m., the LPN stated that she will document in the electronic record that the resident's medication was not available and whether the facility was waiting delivery from pharmacy. She stated that the facility has e-kits (emergency kits) for medications; but, the e-kit have more generic medications and does not have all the medications. The LPN said that if there was a delay in the delivery of the medications resulted in the resident missing a dose, she will not notify the provider. She said that if the medication that was delayed in the delivery will medically impact the resident, for example, blood pressure medications, this needed to be reported to the provider. The LPN stated that if a resident has a seizure disorder, it would not be appropriate for that resident to miss even one dose of the seizure medication. She stated that she had seen clonazepam used to treat seizures and a missed dose of clonazepam would require talking to the doctor. The LPN said that the Assistant Director of Nursing (ADON) have the keys to the e-kit or pyxis; and, she would ask the ADON if clonazepam was available in the facility's e-kit or pyxis. In an interview with the ADON (staff #61) conducted on 6/24/2024 at 4:22 p.m., the ADON accessed the inventory for the facility's pyxis machine and stated that that clonazepam was available in the facility's pyxis. However, the ADON stated that the clonazepam in the facility's pyxis had a different dose than what was ordered for resident #1. The ADON said that resident #1 was ordered for clonazepam 1 mg tablet. She stated that if the resident was just admitted at the facility like resident #1, staff could get a one-time order from the doctor to get the medication from the pyxis and administered to the resident until the pharmacy delivered the medications. During an interview with the Director of Nursing (DON/staff #33) conducted on 6/24/2024, the DON stated that she agreed that if the resident really wanted the medication, then the staff would have to get a new order to pull the new dose of medication from the pyxis. The facility policy on Medication Administration- Administration of Drugs, it included that it is their policy that medications shall be administered as prescribed by the attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Creek Health & Rehabilitation Center	1045 Scott Drive Prescott, AZ 86301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, resident and staff interviews, review of facility documentation and policy, the facility failed to ensure that infection control guidelines related to oxygen use was followed for one resident (#2). The deficient practice could result in the spread of spread of disease to residents. Findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses of primary pulmonary adenocarcinoma (lung cancer) and dyspnea. A physician order dated 6/19/2024 included for 1-5 liters of oxygen as needed via nasal cannula to keep oxygen saturation greater than 90% for shortness of breath related to ineffective gas exchange. Another physician order dated 6/19/2024 included to change oxygen tubing every night shift and as needed. The daily skilled note dated 6/20/2024 revealed that the resident was alert and oriented x3; and that, the resident had no respiratory treatments. The physician admission progress note dated 6/20/2024 included that the resident was alert, ill-appearing, had clear breath sounds and unlabored breathing. Assessments included primary pulmonary adenocarcinoma, dyspnea with exertion and chronic cough. The care plan dated 6/20/2024 revealed the resident had oxygen therapy related to ineffective gas exchange and lung cancer. Interventions included to give medications as ordered by physician, monitor/document side effects and effectiveness, and oxygen 1-5 liters continuously via NC (nasal cannula)/mask. The brief interview for mental status (BIMS) dated 6/21/2024, the resident had a BIMS score of 14 indicating the resident had intact cognition. The MDS (minimum data set) note dated 6/21/2024 included the resident was alert and oriented x3 and had shortness of breath. The daily skilled note dated 6/23/2024 revealed the resident was alert and oriented x3 and had no active respiratory symptoms. The documentation included that respiratory treatments included use of continuous oxygen set at 2 LPM (liters per minute) via nasal cannula. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035131	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Creek Health & Rehabilitation Center	1045 Scott Drive Prescott, AZ 86301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 6/24/2024 at approximately 3:30 p.m., the oxygen tubing including the nasal cannula for resident #2 was on the floor by her bed. Resident #24 stated that she had dropped it when she got up to go to the bathroom. Multiple nursing staff were observed walking past the room and entering the resident room to talk with resident #2 while the resident's oxygen tubing was on the floor. At 4:00 p.m., the resident had her nasal cannula on; and, the resident stated that staff picked the oxygen tubing for her but did not sanitize it. The resident further stated that the staff did not provide her new oxygen tubing. In an interview with Licensed Practical Nurse (LPN/Staff #45) conducted on 6/24/2024 at 4:15 p.m., the LPN stated that if the resident's oxygen tubing, mask or nasal cannula fell on the floor, then the resident would get a new tubing or a mask. Regarding resident #2, the LPN said that she did not notice that the oxygen tubing of resident #2 was on the floor. During an interview with the Assistant Director of Nursing (ADON/staff #61) conducted on 6/24/2024 at 4:22 p.m., the ADON stated that her expectation was for staff to use hand sanitizer gel when they enter and exit the resident room even if they were just talking to the resident. Further, the ADON stated that if the resident's mask or oxygen tubing or nasal cannula fell on the ground, she would expect staff to replace these before putting it back on the resident. A facility policy titled, Oxygen Administration, revealed that staff may replace oxygen tubing as needed. The facility policy on Infection Prevention and Control Program included that it is the facility's goal to decrease the risk of infection to residents, recognize infection control practices while providing care, and identify and correct problems relating to infection control practices.