

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814</p> <p>Based on observations, staff and resident interviews, clinical record and policy review, the facility failed to protect the rights of three residents (#22, #54, #89) to be free from abuse. The deficient practice may result in further resident to resident abuse.</p> <p>Findings include:</p> <p>-Resident #22 was admitted on [DATE] with diagnoses of a Crohn's disease, acute kidney failure, anxiety disorder, bipolar disorder, and depression.</p> <p>The care plan dated January 6, 2022 revealed that resident was taking antidepressant medication related to depression for episodes of crying.</p> <p>Review of care plan dated October 13, 2022 included the resident was on anti-anxiety medication related to restlessness, racing thoughts, and inability to sleep.</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) summary score of 15 which indicated the resident had intact cognition. Moreover, the MDS revealed no indication of atypical behavior or presences of psychiatric/mood disorders.</p> <p>Review of an order dated September 23, 2024 revealed that resident had change of condition due to Behavioral/psychosocial episodes and antianxiety medication dose increase every shift for 3 days.</p> <p>-Resident #54 was admitted on [DATE] with diagnoses of a chronic obstructive pulmonary diseases, sepsis, hypertensive heart disease with heart failure and edema.</p> <p>Review of the MDS assessment dated [DATE] revealed BIMS score of 15 indicating the resident had intact cognition. Further review of the MDS reported no indication of atypical behavior or presences of psychiatric/mood disorders.</p> <p>The facility assessment dated [DATE] regarding Social Services Assessment/Evaluation revealed resident had re-traumatization and showed yelling or swearing behavior and was provided a calm and quiet environment.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #60 was admitted on [DATE] with diagnoses of unspecified cataract, hypertension, benign prostatic hyperplasia and chest pain.</p> <p>The MDS assessment dated [DATE] revealed resident active diagnosis including hypertension, Parkinson's disease, and seizure disorder or epilepsy.</p> <p>Review of an order summary revealed that resident had orders for the following medications: anti-Parkinson's, anticonvulsants, antianxiety and antidepressant.</p> <p>The care plan dated September 18, 2024 revealed that resident had a behavior problem related to clothing preferences. Goal was that the resident will have fewer episodes of walking down the hall without any clothing on. Interventions included to intervene as necessary to protect the rights and safety of others and monitor behavior episodes and attempt to determine underlying cause.</p> <p>An interview was conducted on September 30, 2024 at 11:59 a.m. with resident #22 who stated that resident #60 without wearing clothes, had roamed into resident rooms several times; and that, resident #60 should not be inside her room because resident #22 had scared and frightened her. Resident #22 was tearful at both eyes and was crying throughout the interview. Further, resident # 22 stated that in their last resident council meeting, residents discussed the behavior of resident #60 and had notified administrator (staff #195) and director of nursing (staff #62); but nothing had been done about the resident's inappropriate behavior.</p> <p>An interview was conducted on September 30, 2024 at 1:31 p.m. with resident #55 who stated that she saw resident #60 roaming into the lady's room, and going into the room of resident #54; and, walked into the room of another resident (#36) who was unable to hear. She said that two weeks ago, resident #60 walked into their room, grabbed the wheelchair, and pushed it out to the hall; and that, her roommate saw this and made resident #60 bring the wheelchair back. The resident also said that after that incident she called out for a nurse because resident #60 remained inside their room; and that, the nurse had to remove resident #60 out of their room. She further stated that she did not consider telling anyone about these occurrences because she felt that bringing up the situation would be a problem and had known of people being kicked out from the facility for complaining.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Another interview with resident #22 was conducted on September 30, 2024 at 1:41 p.m. The resident stated that on a Sunday a week ago she had been scared by resident #60 who was yelling right outside the room. The resident said that two nights ago, resident #60 was nude, entered her room and had placed his hands on her bed and told her that he was going to lay on her bed. She stated that she told him not to and resident #60 stood there for a few minutes processing the response before leaving. The resident said that a certified nursing assistant (CNA/staff #168) asked resident #60 to put his clothes on and resident #60 yelled and told the CNA that the CNA was not his boss. The resident also stated that one and a half weeks ago, resident #60 came into her room and slammed into their wheelchair. Further, the resident stated that her roommate could not sleep due to resident #60 and had wanted to call the police because there were items missing including a jar of lotion from their room. The resident stated that she was scared and frightened by resident #60 since moving into the unit. She stated that she was claustrophobic and unfortunately had to keep her room door open. She stated that she had discussed these concerns with the administrator, the director of nursing (DON) and the charge nurse; and that, this resulted in changes in her medication. She said that she was placed on anti-anxiety medication because they thought she was losing it. During the interview, the resident became tearful, cried and stated that resident #60 had hurt her mind and soul. The resident said that when she reported her feelings to the administrator and the DON about a week ago, they told her that maybe it was time for her to go to a new facility. The resident stated that she told them that she had been at the facility for a long time and she was not leaving.</p> <p>In an interview with resident #54 conducted on October 1, 2024 at 7:54 a.m. the resident stated that resident #60 continued to come into their room, as soon as moving in about 2 months ago. She stated that the first time resident #60 came inside their room, resident #60 drank their water and soda. She stated that she requested for resident #60 to get out, but resident #60 told her that he would be getting in bed with her. She stated that she then started screaming and staff came and got him out of the room. However, she stated that resident #60 continued to come again and again and watched them (resident #54 and her roommate) sleeping. The resident said that last Friday night, resident #60 came into the room with his wheelchair and hit her wheel chair; and that, she yelled at him and even after yelling at him to get out, resident #60 did not leave. She stated that staff had to come into the room to get him out. She stated that she did not feel safe in the facility and had spoken to the administrator and the DON following the first incident. The resident said that their solution was to move her to another room because the administrator told her that it was the law that if one resident had a problem then they had to move. She said that she should not move to another room because she liked her current roommate. The resident said that the administrator later placed a red label ribbon do not enter on their door but this did not stop resident #60 from entering their room. She stated that she had been scared ever since hearing and noticing resident #60 outside their room naked; and that, resident #60 had entered about 8 or 9 resident rooms while naked, including their room a month ago.</p> <p>An interview was conducted on October 1, 2024 at 1:01 p.m. with CNA (staff #156) who stated that abuse incidents were reported to the administrator and DON. The CNA stated that the impact on residents who were subjected to abuse may be change in behavior, become more aggressive, or may avoid eating; however, the staff keep residents safe and happy. The CNA said that she had seen resident #60 roaming around the room of residents #54 trying to use their restroom. The CNA also said that the licensed practical nurse (LPN/staff #71) had pulled resident #60 out of the room of residents #54; and that, she was also aware that resident #22 reported that resident #60 was also in her room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on October 1, 2024 at 8:14 a.m. with social service director (staff #59) who stated that when grievances are brought by residents, staff were to ensure the resident feel safe. Staff #59 stated that grievances were documented, would talk to relevant departments, find resolution, and ask the resident if they were satisfied with that.</p> <p>An interview was conducted on October 1, 2024 at 1:31 p.m. with the DON who stated that resident subjected to abuse could result to emotional harm manifested as crying, withdrawn and physical harm manifested as getting injured, bruising. The DON stated that no one should suffer from abuse whether emotional or physical. Further, the DON stated that residents #22 and #54 had brought concerns regarding resident #60 roaming into their room; and that, it upset them.</p> <p>An interview was conducted on October 2, 2024 at 10:12 a.m. with administrator who stated that if there were allegations of abuse, his expectation was for staff to notify him immediately, and to ensure that resident was safe. Further, the administrator stated that he would not like it if someone come into his room uninvited and naked.</p> <p>50887</p> <p>-Regarding Resident #89</p> <p>Resident #89 was admitted into the facility on [DATE] with diagnoses that included fracture of unspecified part of neck, bipolar disorder, and post traumatic disorder.</p> <p>A nursing progress note dated June 3, 2024 at 8:20 PM revealed that there was a physical incident that occurred between resident's #89 and his roommate resident #238; and that, after the incident the roommate had been removed from residents #89's room. Moreover, the progress note revealed that the nurse practitioner was notified and ordered resident #89 to go to the emergency room for further evaluation, however once emergency services arrived the resident #89 refused to go.</p> <p>Review of physician progress note dated June 4, 2024 revealed that the resident reported being punched in the face during the altercation. The note revealed that the resident had a chief complaint of visible bruise to his right eye.</p> <p>Review of the order summary revealed a physician order dated June 4, 2024 to monitor abrasion under left eye, left cheek, and scratch under right eye for infection.</p> <p>Review of care plan initiated on June 4, 2024 revealed re-traumatization related to history of trauma PTSD (post traumatic stress disorder) related to disasters, and altercation with roommate on June 3, 2024 indicated interventions which included: administering medications as orders, anticipate and meet needs, and approach in a calm manner.</p> <p>An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 3 which indicated resident was severely cognitively impaired. Moreover, MDS revealed that the resident was negative for psychosis and behavioral symptoms during the assessment period.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility investigation report submitted on June 10, 2024 revealed that on June 3, 2024 at approximately 8:15 pm resident #89 was poked in the face by resident #238. The investigation report included an interview with the alleged victim. According to resident #89, the incident had occurred while he and his roommate were in their room. The resident stated that resident #238 had come up to him and pointed at him. The report revealed that it was during that time that resident #238 cut resident #89's face with his pointer finger.</p> <p>Review of the facility investigation submitted on June 10, 2024 revealed an interview was conducted on June 5, 2024 with a Certified Nursing Assistant (CNA/staff #260) who stated that resident #238 wanted the television off and resident #89 volunteered to mute the television. The investigation revealed that the CNA told the residents that they had to respect each other's rights. The report revealed that staff #260 had returned approximately 10 minutes later and observed resident #238 standing next to resident #89; and that, resident #89 was observed with a scratch under his eye.</p> <p>An interview was conducted on October 1, 2024 at 01:31 PM with the Director of Nursing (DON/Staff #62) who stated that all staff are trained on abuse upon hire, annually and as needed. The DON stated that the process for a resident to resident altercation includes making sure the resident is safe, separate the residents, report the incident within two hours, and to notify the physician, ombudsman, and family. The DON (Staff #62) stated that neither residents had a history of aggressive or physical behavior. The DON further stated that resident #89 is usually withdrawn and quiet but that was his baseline. DON stated that there had not been any behavior changes since the incident occurred. According</p> <p>to the DON, residents that are subjected to abuse can sustain emotional and physical harm which can include bruising and cuts. Additionally, DON stated that residents can experience pain, crying, being emotionally distraught, and become withdrawn.</p> <p>A review of the facility policy titled, Abuse: Prevention of and Prohibition Against, reviewed October 2023 indicated that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>Review of facility policy regarding Abuse: Prevention of and Prohibition Against revealed that the facility will act to protect and prevent abuse and neglect from occurring within the facility by establishing a safe environment that supports, to extent possible.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814</p> <p>Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure adequate supervision for one resident (#60). The deficient practice resulted in resident wandering into other resident rooms uninvited.</p> <p>Finding includes:</p> <p>Resident #60 was admitted on [DATE] with diagnoses of unspecified cataract, hypertension, benign prostatic hyperplasia and chest pain.</p> <p>The initial admission record dated August 12, 2024 included that the resident was alert and oriented to time, place and person, was able to follow simple commands, had no behavior problems, was ambulatory or self-mobile in the wheelchair.</p> <p>The elopement/wandering evaluation dated August 12, 2024 revealed a score of 5 indicating the resident was low risk for elopement/wandering. Per the documentation, the resident had no elopement history.</p> <p>The MDS (Minimum Data Set) note dated August 15, 2024 revealed the resident was alert and oriented x 3-4, had adequate hearing, was able to understand others and had some difficulty expressing words at times.</p> <p>The MDS assessment dated [DATE] revealed resident active diagnosis including hypertension, Parkinson's disease, and seizure disorder or epilepsy. The assessment included that the resident did not have any behavioral symptoms directed towards others; and that, the reside did not have any wandering behaviors.</p> <p>Review of an order summary revealed that resident had orders for the following medications: anti-Parkinson's, anticonvulsants, antianxiety and antidepressant.</p> <p>The care plan dated September 18, 2024 revealed that resident had a behavior problem related to clothing preferences. Goal was that the resident will have fewer episodes of walking down the hall without any clothing on. Interventions included to intervene as necessary to protect the rights and safety of others, monitor behavior episodes and attempt to determine underlying cause, document behavior and potential causes and frequent reminders for privacy related to clothing.</p> <p>Despite being care planned, the clinical record revealed no documentation found in the clinical record of any incident/s that the resident was walking down the hall without any clothing on.</p> <p>The clinical record no documentation that the resident had any behaviors related to wandering behaviors or entering other resident rooms; and, any type of supervision the resident needed or required.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The care plan was initiated on September 30, 2024 to include that the resident had a potential to demonstrate behaviors related to dementia. Interventions included 1:1 sitter, review for continued need for an ongoing basis, every 15 minutes checks, and monitor for changes in mood and behavior patterns, psychosocial changes and notify the provider if needed.</p> <p>The care plan was revised on October 1, 2024 to included an alleged incident with a female resident.</p> <p>An interview was conducted on September 30, 2024 at 11:59 a.m. with resident #22 who stated that resident #60 without wearing clothes, had roamed into resident rooms several times; and that, resident #60 should not be inside her room because resident #22 had scared and frightened her. Resident #22 was tearful at both eyes and was crying throughout the interview. Further, resident # 22 stated that in their last resident council meeting, residents discussed the behavior of resident #60 and had notified administrator (staff #195) and director of nursing (staff #62); but, nothing had been done about the resident's inappropriate behavior.</p> <p>An interview was conducted on September 30, 2024 at 1:31 p.m. with resident #55 who stated that she saw resident #60 roaming into the lady's room, and going into the room of resident #54; and, walked into the room of another resident (#36) who was unable to hear. She said that two weeks ago, resident #60 walked into their room, grabbed the wheelchair, and pushed it out to the hall; and that, her roommate saw this and made resident #60 bring the wheelchair back. The resident also said that after that incident she called out for a nurse because resident #60 remained inside their room; and that, the nurse had to remove resident #60 out of their room. She further stated that she did not consider telling anyone about these occurrences because she felt that bringing up the situation would be a problem and had known of people being kicked out from the facility for complaining.</p> <p>Another interview with resident #22 was conducted on September 30, 2024 at 1:41 p.m. The resident stated that on a Sunday a week ago she had been scared by resident #60 who was yelling right outside the room. The resident said that two nights ago, resident #60 was nude, entered her room and had placed his hands on my bed and told her that he was going to lay on her bed. She stated that she told him not to and resident #60 stood there for a few minutes processing the response before leaving. The resident said that a certified nursing assistant (CNA/staff #168) asked resident #60 to put his clothes on and resident #60 yelled and told the CNA that the CNA was not his boss. The resident also stated that one and a half weeks ago, resident #60 came into her room and slammed into their wheelchair. Further, the resident stated that her roommate could not sleep due to resident #60 and had wanted to call the police because there were items missing including a jar of lotion from their room. The resident stated that she was scared and frightened by resident #60 since moving into the unit. She stated that she was claustrophobic and unfortunately had to keep her room door open. She stated that she had discussed these concerns with the administrator, the director of nursing (DON) and the charge nurse; and that, this resulted in changes in her medication. She said that she was placed on anti-anxiety medication because they thought she was losing it. During the interview, the resident became tearful, cried and stated that resident #60 had hurt her mind and soul. The resident said that when she reported her feelings to the administrator and the DON about a week ago, they told her that maybe it was time for her to go to a new facility. The resident stated that she told them that she had been at the facility for a long time and she was not leaving.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with resident #54 conducted on October 1, 2024 at 7:54 a.m. the resident stated that resident #60 continued to come into their room, as soon as moving in about 2 months ago. She stated that the first time resident #60 came inside their room, resident #60 drank their water and soda. She stated that she requested for resident #60 to get out, but resident #60 told her that he would be getting in bed with her. She stated that she then started screaming and staff came and got him out of the room. However, she stated that resident #60 continued to come again and again and watched them (resident #54 and her roommate) sleeping. The resident said that last Friday night, resident #60 came into the room with his wheelchair and hit her wheel chair; and that, she yelled at him and even after yelling at him to get out, resident #60 did not leave. She stated that staff had to come into the room to get him out. She stated that she did not feel safe in the facility and had spoken to the administrator and the DON following the first incident. The resident said that their solution was to move her to another room because the administrator told her that it was the law that if one resident had a problem then they had to move. She said that she should not move to another room because she liked her current roommate. The resident said that the administrator later placed a red label ribbon do not enter on their door but this did not stop resident #60 from entering their room. She stated that she had been scared ever since hearing and noticing resident #60 outside their room naked; and that, resident #60 had entered about 8 or 9 resident rooms while naked, including their room a month ago.</p> <p>An interview was conducted on October 1, 2024 at 1:01 p.m. with CNA (staff #156) who stated that abuse incidents were reported to the administrator and DON. The CNA stated that the impact on residents who were subjected to abuse may be change in behavior, become more aggressive, or may avoid eating; however, the staff keep residents safe and happy. The CNA said that she had seen resident #60 roaming around the room of residents #54 trying to use their restroom. The CNA also said that the licensed practical nurse (LPN/staff #71) had pulled resident #60 out of the room of residents #54; and that, she was also aware that resident #22 reported that resident #60 was also in her room.</p> <p>An interview was conducted on October 1, 2024 at 8:14 a.m. with social service director (staff #59) who stated that when grievances are brought by residents, staff were to ensure the resident feel safe. Staff #59 stated that grievances were documented, would talk to relevant departments, find resolution, and ask the resident if they were satisfied with that.</p> <p>An interview was conducted on October 1, 2024 at 1:31 p.m. with the DON who stated that resident subjected to abuse could result to emotional harm manifested as crying, withdrawn and physical harm manifested as getting injured, bruising. The DON stated that no one should suffer from abuse whether emotional or physical. Further, the DON stated that residents #22 and #54 had brought concerns regarding resident #60 roaming into their room; and that, it upset them.</p> <p>An interview was conducted on October 2, 2024 at 10:12 a.m. with administrator who stated that if there were allegations of abuse, his expectation was for staff to notify him immediately, and to ensure that resident was safe. Further, the administrator stated that he would not like it if someone come into his room uninvited and naked.</p> <p>Review of facility policy regarding Elopement/Unsafe Wandering revealed that the residents with capabilities of ambulation and/or mobility in wheelchair will have an elopement/wandering evaluation completed to determine risks for elopement and unsafe wandering on admission and with observed behaviors of wandering or attempts to elope. It further revealed that the resident's care plan will be updated and include interventions to address the possible need for the increased level of supervision.</p>		