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 03/26/2026
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure one of three sampled residents (#25) was provided quality of care regarding prevention, assessment, and treatment of moisture associated skin damage (MASD), according to professional standards. The deficient practice could lead to worsening of a skin issues, increased pain, and physical harm of a resident.-Findings include:Resident #25 was admitted [DATE], with diagnoses that included periprosthetic fracture around internal prosthetic left knee, unspecified fracture of left femur, chronic obstructive pulmonary disease, pneumonia, paroxysmal atrial fibrillation, malignant neoplasm of female breast, and need for assistance with personal care.An Initial admission assessment dated [DATE], revealed Resident #25 had no skin problems on admission.A care plan focus dated March 5, 2026, included that Resident #25 had a pressure ulcer or the potential for pressure ulcer development, due to her comorbidities, and that interventions included to administer treatments as ordered and monitor for effectiveness, to monitor/document/report to the physician as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size and stage, and to notify the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care, and to complete weekly head to toe skin assessment.Physician orders dated March 5, 2026, included: -Encourage and assist resident with repositioning frequently, every shift. -Barrier cream to perineal area for incontinence, every shift. -Weekly skin evaluation every Thursday, day shift, with a start date of March 12, 2026. -Weekly Braden Scale for four weeks, every 7 days, with a start date of March 6, 2026.A daily skilled note dated March 6, 2026, revealed Resident #25 had no skin issues noted, and no active symptoms affecting the integumentary system, and no active skin conditions or treatments observed.A Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE], revealed Resident #25 was scored at 16, indicating low risk for developing pressure-related skin impairment.A nursing note dated March 6, 2026, included that Resident #25 was resting in bed, alert and oriented x 1, and unable to let her needs known to staff.A shower sheet dated March 7, 2026, revealed Resident #25 had redness on the sacral/coccyx area. The shower sheet was signed by a certified nursing assistant (CNA) and a nurse.A daily skilled note dated March 7, 2026, included Resident #25 had a left femur fracture with an immobilizer. The note included the resident had redness to the lower back and coccyx area, and active symptoms included abnormalities in skin color.The clinical record revealed no evidence that the redness/abnormal skin color of the lower back and coccyx area was communicated to the physician.A Late Entry provider progress note dated March 7, 2026, revealed Resident #25's skin was warm and dry without rashes, lesions, or wounds noted.A Late Entry daily skilled note dated March 8, 2026 revealed the resident had a left femur fracture with a leg immobilizer, and the resident had redness to the lower back and coccyx area.The clinical record revealed no evidence that the physician was notified of the redness to the lower back and coccyx area.A provider progress note dated March 8, 2026, revealed Resident #25's skin was warm and dry without rashes, lesions, or wounds noted.A shower sheet dated March 9, 2026, revealed Resident #25 had refused the shower, and included that the resident had a shower the night before last, and did not feel like taking one. The (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower sheet was signed by Resident #25, a CNA, and a nurse.Daily skilled notes dated March 9 and March 10, 2026, revealed Resident #25 had no skin issues noted, and no active symptoms affecting the integumentary system, and no active skin conditions or treatments observed.Provider progress notes dated March 10, 11, and 12, 2026, revealed Resident #25's skin was warm and dry without rashes, lesions, or wounds noted.There was no evidence of any daily skilled nursing notes completed on March 11, 2026.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #25 had a brief interview for mental status (BIMS) assessment score of 10, indicating moderately impaired cognition. Section M - Skin Conditions revealed Resident #25 was at risk for developing pressure ulcers / injuries. The assessment revealed the resident had no moisture associated skin damage (MASD), no unhealed pressure ulcers / injuries, no open lesions other than ulcers, rashes, cuts, and no cuts. The documentation included that the resident had surgical wounds.An Occupational Therapy Treatment Encounter Note, dated March 12, 2026, revealed Resident #25 was dependent on staff for toileting hygiene, and required minimum assistance from staff for rolling left and right in the bed. The note also revealed that decubitus ulcers were observed by the Occupational Therapist on bilateral inner thighs, vagina, buttocks, and right heel. Additionally, improper healing of incision on the left anterior pelvis was observed. The note included that nursing, and wound care nurse were immediately notified of all wounds.There was no evidence of any daily skilled nursing notes or any other nurse progress notes completed on March 12, 2026.A shower sheet dated March 12, 2026, revealed Resident #25 had redness, rashes, and open areas in the genital region, an incision in the left groin area, and redness, skin tears, and rashes on the sacral/coccyx area. The shower sheet was signed by a CNA and a nurse.The clinical record revealed no evidence that a detailed skin assessment was completed for the documented redness, rashes, open areas, and skin tears on March 12, 2026.A physician order dated March 12, 2026, included to wash with soap and water at each brief change and cover reddened areas with Zinc cream, and powder perineal area after each brief change.There was no evidence of a change of condition monitoring order for the skin condition on March 12, 2026.Review of the Medication and Treatment Administration Record (MAR / TAR) for March 2026, revealed a scheduled weekly skin evaluation was not marked as competed on March 12, 2026. Additionally, a scheduled Braden scale assessment was not marked as completed on March 13, 2026.The clinical record revealed no evidence that a Braden scale assessment was completed as ordered on March 13, 2026.A Weekly Skin Evaluation created and signed on March 13, 2026 by the wound nurse (Staff #66) however dated March 12, 2026, revealed that Resident #25 had surgical incisions with staples on the abdomen and left knee. There was no evidence of documentation regarding a skin issue on the resident's sacrum/coccyx.A Skin Ulcer Non-Pressure Weekly assessment created and signed March 13, 2026 by Staff #66, however dated March 12, 2026, revealed the resident had multiple surgical wounds to the left knee and left side of abdomen under pannus, with an onset date of February 24, 2026. There was no evidence of documentation regarding a skin issue on the resident's sacrum/coccyx.There was no evidence of any daily skilled nursing notes completed on March 13, or 14, 2026.Review of the MAR / TAR for March 2026, revealed that the record was not marked as completed for the physician orders to apply barrier cream to peri-area for incontinence every shift and to encourage and assist resident with repositioning frequently every shift for the day shifts on March 6, 7, 10, 12, 13, and 14.A daily skilled note dated March 15, 2026, revealed the resident had a left femur fracture with leg immobilizer, and that the resident's skin was clean, dry, intact, and warm to touch. Additionally, that there were no active symptoms affecting the integumentary system observed, and no active skin conditions or treatments observed.A shower sheet dated March 16, 2026, revealed Resident #25 had open and red areas in the genital region, staples in the left groin area, bruises and a cast on the left leg, and open and red areas on the sacral / coccyx area. Additional comments included that the resident's bottom and area in between legs were painful and the open areas were bleeding. The shower sheet was signed by a CNA and a nurse.The clinical record revealed no evidence that the resident's skin issues including red, painful, open, and (continued on next page)

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Staff #99 stated that it would not meet her expectation of identifying, assessing, and treating a skin condition, and that the risk to residents could be worsening skin conditions.A telephonic interview was conducted on March 26, 2026, at 13:00 p.m. with an LPN (Staff #5) who stated that she recalled working with Resident #25, and that Staff #5 had been notified by other staff that the resident had redness on her sacrum, but could not specify further details of how the skin appeared or when she was notified.An additional telephonic interview was conducted with an LPN (Staff #17) on March 26, 2026, at 5:42 p.m. who stated that she was familiar with Resident #25 and had cared for the resident when the resident was moved to the 400 hall, and that the resident had a skin issue on her sacrum that was already present from before the resident transferred to the 400 hall. Staff #17 stated that she was notified by a CNA that the resident was bleeding from the skin on her sacrum. Staff #17 stated that she then looked at the skin area on the resident's sacrum and noted that there was a large amount of blood from the skin on her sacrum, and that the area was caused by MASD from urine. Staff #17 declined to state whether she had notified either the provider or wound nurse regarding the bleeding skin issue, however did state that she knew the wound nurse was already aware of the issue.Review of the facility policy titled Wound Management, dated July 2025, revealed the nurse responsible for assessing and evaluating the resident's condition on admission are expected to take the following actions: complete comprehensive admission assessment/ evaluation and Braden Scale to identify risk and to identify any alterations in skin integrity noted at that time, develop comprehensive care plan if indicated following the evaluation/assessment, care plans must be individualized and designed to meet the needs of the particular resident for whom they are being developed, and complete weekly head to toe skin assessment with follow up as applicable. Once a wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's order. All wound or skin treatments should be documented in the resident's clinical record at the time they are administered. To prevent the development of skin breakdown or prevent existing pressure ulcers from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: Monitor impact of interventions and modify interventions as appropriate based on any identified changes in condition, reposition the resident as tolerated, and if the resident is incontinent, make sure that his/her skin remains clean and dry with regular peri-care and toileting when appropriate. Review and/or re-evaluate existing treatment regimen in connection with the resident's clinical presentation, to include current interventions and care plan considerations, if any wound is non-healing or not showing signs of improvement after a given time or any time a wound is worsening.Review of facility policy titled Physician Orders, dated June 2025, revealed it is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. Medication, treatment or related procedure orders are transcribed in the MAR / TAR accordingly.Review of the facility policy titled Documentation and Charting, revised July 2022, revealed it is the policy of the facility to provide a complete account of the resident's care, treatment, response to care, signs, symptoms, etc., as well as the progress of the resident's care, guidance to the physician in prescribing appropriate medications and treatments, as well as nursing services personnel with a record of the physical and mental status of the resident.Review of the facility policy titled Change of Condition Reporting revised July 2025, revealed it is the policy of the facility that all changes in resident condition will be communicated to the physician. Unusual signs and symptoms (continued on next page)

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