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	10/02/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, interview, and review of the facility's policies, the facility failed to ensure that 7 of 7 sampled residents (#65, #344, #38, #13, #19, #58, and #33) were provided a comfortable and homelike environment. The deficient practice could have a negative psychosocial impact on residents. -Regarding Residents #65 and #344: An observation was conducted on September 30, 2024 at 10:43 AM of room [ROOM NUMBER] belonging to Resident #65 who was not in the room at that time. From the doorway, observation of the wall revealed that paint had been scraped off of behind and surrounding the headboards of both A and B beds. An additional observation was conducted of the wall in room [ROOM NUMBER] later that day on September 30, 2024 at 2:25 PM. Per the floor nurse, Resident #65 was still out at an appointment. The area where the paint had been scraped off of the wall had still not been re-painted over. It appeared white where the paint had previously been scraped off, in contrast to the tan color of the wall paint. On October 02, 2024, at 10:48 AM, an additional observation was conducted of room [ROOM NUMBER]. At that time, Resident #65 had discharged , and Resident #344 had admitted into the room. The area where the paint had been scraped off of the wall had still not been repaired. Numerous areas of paint damage were present, with each white area appearing approximately 4-5 inches wide. An interview was conducted on October 02, 2024, at 12:30 PM, with Resident #344 who was in the room at that time. Resident #344 stated that he had noticed that the paint was scraped off of the walls around the headboards of the beds, and that if the room looked messy, that it would bother him. Supplemetal visual evidence of room [ROOM NUMBER] were obtained during observation. -Regarding Residents #38 and #13: (continued on next page)

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	10/02/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted on October 02, 2024, at 10:51 AM, of room [ROOM NUMBER] belonging to Resident #38 and Resident #13. From the doorway, observation revealed that paint had been scraped off of the wall behind and surrounding the headboard of Resident #38's bed. Additionally, there were patches with missing paint on the wall above and to the left side of Resident #13's bed. Further, observation revealed paint scraped off of the wall with broken and damaged drywall visibly on the wall below the resident's window and located approximately 12 inches above the floor. -Regarding Resident #19: An observation was conducted on October 02, 2024, at 10:54 AM of room [ROOM NUMBER] where Resident #19 resided. Observation revealed elongated area of paint, approximately 1-4 inches high by approximately 4 feet long had been scraped off of the wall, easily seen from the doorway of the room. The area was located about 1-2 feet above the floor, and under the window. The drywall was damaged and broken in that area. -Regarding Residents #58 and #33: An observation was conducted on September 30, 2024 at 12:48 PM of room [ROOM NUMBER], belonging to Resident #58 and Resident #33. On the ceiling, directly above Resident #58's bed, was a crack with a liquid residue stain on the ceiling. An additional observation was conducted on October 02, 2024, at 12:35 PM of the ceiling in room [ROOM NUMBER]. The crack on the ceiling was still present. It was approximately 2 feet long, and the brown colored liquid residue mark surrounding the crack was still present as well. In an interview was conducted at that time with Resident #58, who stated that it was important to her how her room looked, and that the crack on the ceiling had been there for as long as she had been there. An interview was also conducted with Resident #33 on October 02, 2024 at 12:38 PM. Resident #33 stated that the ceiling crack had been there longer than she had been there, and further specified that she had been there for over a year. She stated that it looked like there was water dripping because of water marks around it, and that it bothered her because it is unsightly. She stated that she had told facility staff about it when she first moved into the room. On October 02, 2024 at 11:03 AM, an interview was conducted with the Maintenance Director (Staff #55), who stated that he performed daily walk through the building to assess the need for repairs or maintenance tasks. On October 02, 2024 at 1:42 PM an additional interview was conducted with Staff #55, who stated that his daily maintenance walk-throughs include walking through each hallway. He stated that room checks were done weekly. He also stated that, when a new admission is scheduled to come into a room, staff were trained to inspect the room and to look for any needed maintenance repairs, and then notify him. He stated that if a maintenance issue was noticed, then they fix it when the issue is found. (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	10/02/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At this time, a walk-through was conducted alongside Staff #55 through rooms 104, 402, 404, and 412, where the missing paint areas, damaged drywall areas, and the crack in the ceiling were all observed. Staff #55 stated that the facility ordered new beds with extended bumpers on the headboard side of the bed to help protect the paint from being scraped off the wall. He stated that the paint being scraped off of the walls from the beds won't be an issue in the future. On October 02, 2024 at 1:54 PM, an interview was conducted with the Administrator (Staff #195). The Administrator stated that as far as the building appears, we do our best to keep it a homelike environment, so that residents can enjoy their space. He stated that the importance of timely maintenance work was to ensure that the building looks and feels good. If maintenance issues were not reported timely -- then the building might not appear as attractive as we would want it to be, and this could cause dissatisfaction with the residents. Staff #195 stated that the facility had recently secured a quote from a construction company to provide a facelift for the rooms in order to improve them; and that, there are intensified efforts over the past year to ensure that building appearance is being fixed. Review of the facility's policy titled Homelike Environment, revised May 2022, revealed that the facility will provide a homelike environment. An additional review of the facility's policy titled Maintenance Request/Work Orders, revised September 2023, revealed the facility will maintain a clean, well repaired building, and provide staff to report any issues needing attention. Work requests must be in the form of work orders, not verbal.

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	10/02/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 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. Findings include: -Resident #22 was admitted on [DATE] with diagnoses of a Crohn's disease, acute kidney failure, anxiety disorder, bipolar disorder, and depression. The care plan dated January 6, 2022 revealed that resident was taking antidepressant medication related to depression for episodes of crying. 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. 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. 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. -Resident #54 was admitted on [DATE] with diagnoses of a chronic obstructive pulmonary diseases, sepsis, hypertensive heart disease with heart failure and edema. 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. 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. -Resident #60 was admitted on [DATE] with diagnoses of unspecified cataract, hypertension, benign prostatic hyperplasia and chest pain. The MDS assessment dated [DATE] revealed resident active diagnosis including hypertension, Parkinson's disease, and seizure disorder or epilepsy. Review of an order summary revealed that resident had orders for the following medications: anti-Parkinson's, anticonvulsants, antianxiety and antidepressant. (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	10/02/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. (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	10/02/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 50887 -Regarding Resident #89 (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	10/02/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. 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. 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 returend 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. 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 (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	10/02/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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.

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	10/02/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 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. Finding includes: Resident #60 was admitted on [DATE] with diagnoses of unspecified cataract, hypertension, benign prostatic hyperplasia and chest pain. 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. 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. 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. 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. Review of an order summary revealed that resident had orders for the following medications: anti-Parkinson's, anticonvulsants, antianxiety and antidepressant. 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. 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. 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. (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	10/02/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. The care plan was revised on October 1, 2024 to included an alleged incident with a female resident. 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. 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. 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. (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	10/02/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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.

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	10/02/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, record review, interviews, and facility policy review, the facility failed to ensure respiratory services were provided according to professional standards, specifically that an order was obtained for the use of oxygen, for one resident (#339). The deficient practice could result in residents receiving unnecessary supplemental oxygen, and the provider not being aware of the resident's status. -Findings include: Resident #339 was admitted into the facility on [DATE], with diagnoses that included congestive heart failure, hypertension, and coronary artery disease. A review of the resident's hospital discharge orders dated September 27, 2024 revealed no orders for oxygen use. The admission minimum data set assessment (MDS) had not yet been completed due to the resident's newly admitted status. Review of the facility's physician orders conducted on September 30, 2024 at 1:19 PM, revealed no evidence of orders for oxygen administration. On October 01, 2024 at 10:44 AM an additional review of resident #339 physician orders revealed no evidence of orders for oxygen administration. On October 02, 2024 at 7:22 AM a follow-up review of the facility's physician orders was conducted which revealed evidence of a new physician order placed on October 1, 2024, for oxygen at 1-5 liters per minute via nasal cannula continuously for shortness of breath, may titrate to maintain oxygen saturation greater than 90%. Review of Resident #339's care plan initiated September 28, 2024, revealed no care plan regarding oxygen administration. Upon review of the resident's progress notes, there was no evidence of provider notes including the initiation or administration of oxygen. There was no evidence of nurse-to-provider or provider-to-nurse communication regarding a change of respiratory status or the initiation of oxygen. A Daily Skilled nursing note dated September 28, 2024, revealed the resident was on room air. A Daily Skilled nursing notes dated September 29, 30, and October 1, 2024, revealed the resident was on, Oxygen via Nasal Cannula. A review of the O2 Summary log revealed that Resident #339 was documented to be on Room Air on September 28, 2024, however the log revealed that the resident was on Oxygen via Nasal Cannula on September 29, 2024 and September 30, 2024. (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	10/02/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation conducted on September 30, 2024, at 10:50 AM, revealed Resident #339 was lying in bed in his room, receiving oxygen through a nasal cannula, with the concentrator at bedside set at 1 liter per minute. An additional observation conducted on October 01, 2024, at 9:08 AM, revealed the resident receiving oxygen via nasal cannula, with the concentrator set at 1 liter per minute. An interview was conducted with Resident #339 on September 30, 2024, at 10:50 AM. The resident stated that he was not sure what oxygen dose he was supposed to be on, and that he was not sure why he was supposed to be here. In an interview conducted on October 01, 2024, at 11:08 AM, an admissions nurse/registered nurse (RN/Staff #144) stated that when a resident admits to the facility from the hospital and has orders for oxygen administration, that Staff #144 transcribes those orders into the facility's physician orders. An interview was conducted on October 01, 2024, at 11:12 AM with a licensed practical nurse, (LPN/Staff #71) who stated that if a resident was experiencing a change of condition in which the nurse believed a resident required oxygen, that she would notify the provider, obtain an order for oxygen, and apply oxygen as per the physician order. Moreover, Staff #71 stated she would notify family or the responsible party, and would put the resident on a change of condition status, which is specific monitoring for three days. In an interview conducted on October 01, 2024, at 11:28 AM, an Assistant Director of Nursing/licensed practical nurse (ADON/Staff #159) stated that if a resident was experiencing a change of condition in which a nurse believed the resident may require oxygen, that the nurse would then contact the provider, follow the provider's orders, and transcribe those orders into the facility's physician orders. Staff #159 also stated that when oxygen is used as a treatment intervention, that a care plan is put into place. When Resident #339's discharge orders from the hospital were reviewed together, the ADON stated that no orders for oxygen could be found. When the facility's physician orders were reviewed together, the ADON also stated that no orders for oxygen use could be found. Finally, Resident #339 was visited alongside ADON at his room, and Staff #159 confirmed that oxygen was in use. An interview was conducted on October 01, 2024 at 12:09 PM with the Director of Nursing (DON, Staff #62). The DON stated that if a resident was noted to experience a respiratory change of condition or a deviation from baseline, that a nurse would complete an assessment of the resident, initiate a change of condition status, notify the provider, and would document in a progress note or assessment in the medical record. When reviewing the medical record together for Resident #339, the DON stated that there were no notes with evidence of a respiratory change of condition or initiation of oxygen use. The DON stated that it was her expectation that nursing documentation be completed timely; and that, any new oxygen orders should be in place for the next shift. Additionally, the DON stated that the importance of timely nursing documentation is what allows the nurses on the following shifts to know what was implemented for a resident. (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	10/02/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Oxygen Administration, revised July 2013, revealed that oxygen therapy is administered as ordered by the physician or as an emergency measure until the order can be obtained. The purpose of oxygen therapy is to provide sufficient oxygen to the blood stream and tissues. Further, the resident's medical record will include that oxygen is to be administered, when and how the oxygen is to be administered, and the type of oxygen device to use. Review of the facility's policy titled Documentation and Charting, revised July 2022, revealed that the facility is to provide a complete account of the resident's care, treatment, response to care, signs, symptoms, as well as progress of the resident's care.

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	10/02/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51124 Based on observation, staff interviews, and policy review, the facility failed to ensure that a medication cart was locked when unattended and that controlled medications in the medication storage room were properly secured according to facility policy. The deficient practice could result in residents or staff members having unrestricted access to medications and controlled substances. -Regarding the medication cart: An observation was conducted on October 01, 2024, at 7:28 AM in the hallway of the 400 unit. It was observed that a medication cart was unlocked without staff presently attending it or in close proximity. A nurse was observed to be in a room across the hall from the med cart, attending to the resident in the bed furthest from the door, looking opposite and away from the cart. An interview was conducted with this Licensed Practical Nurse (LPN, Staff #49) on the same day at 8:33 AM. Staff #49 acknowledged that she had left the cart unlocked while she was administering medication during med pass. An interview was conducted on October 02, 2024 at 11:28 AM with the Director of Nursing (DON, Staff #62). The DON stated that it was her expectation that a medication cart should be locked if a nurse leaves their assigned medication cart. -Regarding the controlled substance: An observation was conducted on October 02, 2024 at 7:34 AM, of the medication storage room with a Licensed Practical Nurse (LPN, Staff #154). Observation of the medication storage room revealed two brown plastic storage containers stacked upon each other and placed next to the facility's e-kit (automated dispensing cabinet for secure medication management). Staff #154 identified the brown plastic boxes as back-up e-kit boxes. Neither box was locked and the flip-up lids of the boxes were easily opened. The contents of the first box were examined. Inside the first box was another clear plastic storage box with multiple compartments present. The inner plastic box was held shut by a thin red plastic zip tie that could easily be cut or torn. The zip tie did not have a locking mechanism or code. It was observed that multiple pills were present in the separate compartments of the clear plastic box, and the different compartments were labeled with the name of the medication and the quantity of pills. The labels included the following: -tramadol 50 milligram x 5 -hydrocodone 5/325 milligram x 5 -hydromorphine 2 milligram x 5 (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	10/02/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-methadone 5 milligram x 10 -temazepam 15 milligram x 2 The second brown plastic box was easily opened with no lock securing it. Inside was a clear plastic storage box with a thin red zip tie holding the box shut. This box also contained numerous pills, and was labeled as follows: -morphine sulf IR 15 milligram x 4 -tramadol 50 milligram x 5 -hydrocodone 5/325 milligram x 5 -hydromorphine 2 milligram x 5 -methadone 5 milligram x 10 -temazepam 15 milligram x 2 On October 2nd, 2024, at 8:02 AM, an interview was conducted with the Director of Nursing (DON, Staff #62). The DON stated that the process for storing narcotics was to double-lock the medications. She also stated that in the nurses' carts contain a second locking box within the carts. She further stated the e-kit holds the narcotics in the medication storage room, and the nurses can obtain access to the e-kit by calling the pharmacy for a code to get into the e-kit, and there must be an additional witness at that time. The DON stated that even if the e-kit is not working, it is locked and secured; and that, the pharmacy would send out a technician. The DON stated that approximately 1-2 weeks ago, the e-kit was malfunctioning, and the pharmacy company provided the facility 2 backup e-kit boxes that currently need to be picked up by the pharmacy. Review of the facility's policy titled Medication Access and Storage, E Kit Access, revised July, 2024, revealed that it is the policy of the facility to store all drugs in locked compartments, and that the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms and carts are locked or attended by persons with authorized access. Further, Schedule III and IV controlled medications are stored separately from other medications in a locked drawer or compartment designed for that purpose. Schedule II medications are stored in a separate area under double lock. Review of the facility's policy titled Controlled Medications - Storage and Reconciliation, revised December, 2023, revealed that controlled medications are substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency Schedules II-V), have a potential for abuse, and may lead to physical or psychological dependence. Medications listed in Schedule II-V are stored under double-lock location in a locked cabinet or safe designed for that purpose, separate from all other medication.

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	10/02/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on clinical record review, staff interviews, facility documentation and review of facility policy and procedure, the facility failed to ensure dental needs were met for one sampled resident (#58). The deficient practice could result in residents not receiving necessary services for oral and dental care. Findings include: Resident #58 was admitted to the facility on [DATE] with diagnoses that included subluxation of the right shoulder joint, sequelae of cerebral infarction, hypertension, major depressive disorder, hyperlipidemia, and acute kidney failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. Further review of the MDS did revealed that Section L - Oral/Dental Status was blank. Review of a physician order dated December 20, 2023 revealed dental consultation and treatment as needed. Review of the quarterly Nutrition evaluation dated March 19, 2024 revealed that the dentition section for both upper and lower was left blank. A physician progress note dated April 10, 2024 revealed that Patient A presents with reports of teeth pain. The patient note with really bad oral hygiene with reports of extreme pain in her mouth, new order in place to change patient pain regimen. Moreover, revealed that Will also have patient follow up with the dentist. A physician's order dated April 11, 2024 prescribed a dental consult regarding the resident's teeth pain. Review of the resident's clinical record revealed an e-MAR (electronic Medication Administration Record) note dated April 11, 2024 revealed a dental consult related to teeth pain, one time a day for dental pain for 3-days. However, further review of the resident's clinical records did not reveal any dental referral notes. Furthermore, it did not reveal any documentation regarding a dental visit, or that a visit occurred. A progress note dated April 16, 2024 revealed that during the nurse practitioner visit the resident reported experiencing teeth pain. The note revealed that the resident actively participated in assessments and discussions, expressing discomfort and requesting attention for her dental issue. The note indicated that arrangements were being made for the resident to be seen by a dentist to address her teeth pain directly. (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	10/02/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An e-MAR note dated April 21, 2024 revealed a change of condition for oral antibiotics for teeth infection. The note indicated that the resident started the first dose during that shift. Another e-MAR note dated April 22, 2024 indicated a change of condition for oral antibiotics for teeth infection. Review of note revealed that the resident started her antibiotics last evening, the resident continued with pain, and that the Case Management was notified to set up a dental appointment for patient for dental care. However, further review of the clinical record did not reveal any documentation that an appointment was scheduled around that time. Review of the resident's clinical records revealed an e-MAR note dated April 23, 2024 documented a change of condition for oral antibiotics for teeth infection. The note revealed that PRN (as needed) medication were given for complaint of toothache. Another e-MAR note dated April 24, 2024 regarding change of condition for oral antibiotics for teeth infection documented that resident was doing well. However, resident had reported pain throughout the day. The note stated that PRN (as needed) pain medications were given and were effective. A care plan pertaining to the resident's tooth infection was initiated on April 22, 2024 revealed that the resident was on antibiotics until April 28, 2024. Interventions included to follow-up dentist appointment when antibiotics were completed. A physician order dated May 31, 2024 revealed to send resident to a dental facility on June 5, 2024 at 8:15 a. m. However, further review of the resident's clinical record did not reveal any dental referral/encounter notes. Additionally, it did not reveal any documentation of the dental visit or if that visit had occurred. Review of a quarterly Nutrition evaluation dated June 18, 2024 revealed that the resident had her own upper and lower teeth. However, the assessment indicated additional information to document whether the resident's teeth had carious or if resident had some missing teeth. A physician progress note dated June 27, 2024 marked late entry, revealed that the resident needs to follow-up with a dentist for resident's dental caries. A comprehensive visit progress note dated July 29, 2024 revealed that resident was positive for poor dentition. According to the review of systems portion of the note, the resident had to be seen by a dentist soon to have all of her teeth pulled and get dentures. The physical exam portion of the note indicated that the resident was partially edentulous and did not have dentures. Additionally, the note revealed a diagnosis of dysphagia, orpharyngeal phase with a [NAME] that stated dysphagia related to chewing issues from missing teeth. The note further revealed that resident had a follow-up appointment with facility dentist to pull all of her teeth and then supply dentures and to monitor. (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	10/02/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Dental Appointment Note dated August 8, 2024 revealed that the resident was seen for full-mouth radiographs, caries risk assessment, fluoride treatment, full-mouth debridement, and periodontal and restorative charting. The note did not indicate if resident had further dental treatment needs. A physician note dated August 23, 2024 stated Dysphagia related to chewing issues from missing teeth. The note revealed that resident had follow-up appointment with facility dentist to pull all of her teeth, supply dentures, and monitor. However, further review of the resident's clinical record did not reveal any documentation of a dental appointment or mention of resident's dental status. Review of the September 19, 2024 quarterly Nutrition evaluation indicated that the resident had her own upper and lower teeth for dentition. However, the assessment did not indicate additional information to document whether the resident's teeth was carious or if resident had some missing teeth. On October 2, 2024, a physician order dated October 2, 2024 reviewed revealed follow-up appointment with the facility's contracted dental provider on October 10, 2024 pending POA (Power of Attorney) approval. Additionally, on October 2, 2024 the facility provided a faxed treatment plan from the contracted dental provider dated October 2, 2024 was provided by the facility. The dental treatment plan indicated that the resident required multiple tooth extractions and interim mandibular dentures. The cover sheet of the faxed treatment plan noted that the POA will be contacted once the dental provider knows when the next date is that they will be in the facility. A nursing note dated October 2, 2024 revealed that the facility attempted to contact the POA three times that day to confirm dental acceptance of dental appointment for resident on October 10, 2024. Lastly, another faxed note from the facility's contracted provider dated October 2, 2024 listed the names of the residents seen on August 8, 2024 and services rendered. According to the note, the resident was only seen for an exam. The cover sheet revealed that the referral for the resident was received by the contracted dental provider on July 22, 2024 which indicated was months after the resident's dental issues were first identified. During an interview with resident #58 conducted on September 30, 2024 at 12:46 p.m., the resident stated that her teeth need to be pulled. Resident #58 stated that dentist had looked at them but had not seen anyone for her teeth since. An interview with the Director of Social Services (staff #205) was conducted on October 2, 2024 at 10:44 a.m. who stated that her job mainly consists of grievances and assessments. However, was unsure if those were her only duties based on her job description. The Director of Social Services noted that no one passed on any tracker for resident care follow-up. Staff #205 also indicated had not received any communication with nursing services regarding resident's care. Staff #205 stated that as far as she knows, it would be Case Management that would know about care of residents' follow-up care. However, she is unsure if Case Management does this for both skilled and long term care residents. (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	10/02/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Case Manager (staff #210) conducted on October 2, 2024 at 11:50 a.m., staff #210 stated that they are covering for Social Services regarding dental services. The Case Manager said that depending on the need for referral for dental care, the contract company and unit secretary coordinate. Staff #210 said that normally the doctor will put in a referral for care, then transport is set-up. The Unit Secretary (staff #134) tracks who needs follow-up appointments and schedules them. Another coordinates to see if dental services could be approved through the resident's insurance. In an interview with the Unit Secretary (staff #134) conducted on October 2, 2024 at 12:04 p.m., staff #134 noted that usually nursing puts in the order and notify case management then she is notified after. The Unit Secretary said that she schedules the needed appointment and arranges transportation for the resident to attend their appointment. She indicated that in regards to dental services, the contract company normally comes to the facility on ce a month. Staff #134 noted that resident #58 was last seen for dental in August 2024; and that, was the only information she had and it did not reveal whether the resident need further dental treatment. She noted that she would reach out to the dental provider and get the information to determine the residents need and provide it to the survey team. A follow-up interview with resident #58 was conducted on October 2, 2024 at 1:38 p.m. Resident #58 stated that she is unsure of when she last saw the dentist. She confirmed that she had pain while eating. However, she noted that she does not remember if she had told anyone about the pain. During an interview with a Certified Nursing Assistant (CNA/staff #156) conducted on October 2, 2024 at 1:53 p.m., staff #156 stated that if a resident complains of dental pain or pain in general that they would report it to the nurse. Staff #156 stated that it is important to get dental issues taken care of since it can lead to something more serious. Additionally, the CNA said that dental pain/issues can impact the resident's ability to eat since a resident will not eat if they are in pain. Staff #156 noted that resident #58 had not mentioned anything about dental or oral pain. An interview with a Licensed Practical Nurse (LPN/staff #61) was conducted on October 2, 2024 at 3:02 p.m. Staff #61 said that if they received a report that a resident is having pain, they assess for what is causing the pain. If it is something simple, they try things such as positioning for starters to see if resident can get comfortable. The LPN noted that they will check to see if there is an order for PRN (as needed) or scheduled pain medication to see about managing the pain. If the medication and distraction are not working, then they notify the doctor to see what needs to be done. Staff #61 stated that If the issue is dental related, they ask the resident to: describe the pain, when it started, and what makes it worse. The LPN said that they ensure there was no trauma then forward the information to the provider to see what needs to be done or if a dental appointment has to be scheduled. Staff #61 stated that the impact on residents that do not get their dental needs taken care of is that it can lead to infection so it is important to get it resolved. Additionally, the LPN noted that it can cause the resident discomfort. In the case of resident #58, since the dental issue was previously identified, it should have been followed-up. Moreoever, staff #61 stated that it was 100% inappropriate for the dental issue to go unresolved if it was already previously identified based on standing orders and progress notes. It should have been followed-up and scheduled for treatment. (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	10/02/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/staff #62) conducted on October 2, 2024 at 4:03 p.m., staff #62 stated that her expectation was that staff alert the provider if a resident is having dental issues or concerns. The DON indicated that she expected nursing to follow-up and ensure there are no outstanding appointments for the residents' dental needs. Staff #62 noted that this is important because oral health is part of a resident's overall health. If dental needs are not taken care of it can cause the resident pain, infection, and even weight loss. The facility policy titled Dental Services revised January 2024 indicated that it is the facility's policy to ensure that its residents who require dental services on a routine or emergency basis have access to such services without barrier.

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	10/02/2024

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 51006 Based on observations, staff interviews and policy review, the facility failed to provide food within safe serving temperature. The deficient practice could result in foodborne illnesses among residents. Findings include: On October 1, 2024 at 12:12PM, the lunch tray line was observed, and the initial temperatures of the food were as follows: meat at 149 degrees Fahrenheit, the starch temped at 178 degrees Fahrenheit, the pasta salad temped at 70 degrees Fahrenheit. During this observation, staff #123 was interviewed and stated that the pasta salad will be put on ice to assist with the cooling of the component as it was not at their desired temperature range. On October 1, 2024 at 1:33PM, a test tray was brought into the conference room after being closely monitored and followed throughout the facility. The final temperatures of the food were as follows: Meat at 96.4 degrees Fahrenheit; Tater tots at 95.7 degrees Fahrenheit; Pasta salad at 75.6 degrees Fahrenheit; While Staff #11 was observed temping each food component, without sanitizing the temperature rod utilized by staff throughout the demonstration process. During this observation, staff #11 was interviewed regarding the palpability of the food, to which staff reported that the temperature of the food were not to professional standards, and, that the expectation of proper sanitization is to sanitize the temperature rod in-between temping food components. An interview on October 2, 2024 at approximately 12:40 PM was conducted with dietary manager (staff #14) who stated that the expectation with food storage, preparation, distributing and serving food is that staff is to complete the labeling and dating food, keeping the areas clean, washing their hands, and maintaining appropriate temperatures. And reported that the risk of improper palpable temperatures can get people sick. Review of the provided kitchen policies, which were policies titled, 'Dietary Policy', 'Code of Dress Code and Personal Appearance', 'Proper Handwashing and Glove Use', 'Nutrition', 'Resident/Personal Food Storage', and 'Sanitization of Dining and Food Service Areas', revealing that there is no policy is in place for maintaining appropriate food temperatures.

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	10/02/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on observations, resident and staff interviews, and record review, the facility failed to ensure one resident's (#58) dietary needs were met. The deficient practice could place residents at risk of malnutrition and dissatisfaction with their meals. Findings include: Resident #58 was admitted to the facility on [DATE] with diagnoses that included subluxation of the right shoulder joint, sequelae of cerebral infarction, hypertension, major depressive disorder, hyperlipidemia, and acute kidney failure. Review of the nutrition care plan initiated on December 21, 2023 indicated a goal in which resident will maintain adequate nutritional status by maintaining weight with no signs and symptoms of malnutrition. Interventions included: provide, serve diet as ordered and registered dietitian to evaluate and make diet change recommendations PRN (as needed). Further review of the care plan did not indicate or address the resident's gluten allergy. A quarterly Nutrition evaluation dated March 19, 2024 revealed that the resident needed a gluten free diet order. The top portion of the evaluation which contains pertinent resident information noted that the resident had a gluten allergy. Review of the resident's order summary revealed a physician order dated April 10, 2024. The order prescribed a regular diet, mechanical soft texture, thin liquid consistency, upright for meals, gluten free, and sandwiches cut in quarters. A quarterly Nutrition evaluation dated June 18, 2024 documented that the resident had a gluten allergy. The diet order indicated regular, gluten free diet that is mechanical soft in texture/consistency. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. Review of the quarterly Nutrition evaluation dated September 19, 2024 indicated that the resident had a gluten allergy documented under the Identified Dietary Needs for Dietary Interventions section that resident had gluten allergy. However, the diet order did not indicate that the resident needed a gluten free diet which was previously identified in the resident's previous nutrition evaluations. Review of the resident's electronic record on the dashboard under allergies section revealed that the resident had a gluten allergy. Furthermore, review of the resident's clinical record revealed that the allergies portion of the progress notes identified that the resident had a gluten allergy. (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	10/02/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Week 4 (September 29, 2024 through October 5, 2024) had not indicated if any of the items served were gluten free. Review of the facility's Always Available alternative menu listed the following items: Grilled Cheese, Turkey & Cheese Sandwich, PB & J (Peanut Butter & Jelly), Side Salad, Fruit Cup, Gelatin, Yogurt, Applesauce, Cottage Cheese, and Pudding. The menu had not indicated whether the items were gluten free. During the tray line observation conducted on October 1, 2024 at 12:30 p.m. The [NAME] (staff #123) tater tots and mashed potatoes were seen on the plate for resident #58's lunch. An interview with resident #58 was conducted on September 30, 2024 at 2:07 p.m. who stated was not not happy with the food. According to resident #58 she was not offered substitutions other than sandwiches which are not gluten free. The resident indicated that there were no actual substitutes for her dietary needs. The resident stated that she had a gluten allergy ; and that, the food in the facility did not accommodate for her gluten allergy. In an interview with the [NAME] (staff #123) conducted on October 1, 2024 at 11:33 a.m., staff #123 stated that for today's menu consisted of hamburgers, French fries and pasta salad, however those that have gluten allergy will receive a patty with toppings on top - no bread. During an interview with the Dietary Supervisor (staff #70) conducted on October 2, 2024 at approximately 12:35 p.m., staff #70 stated that for residents with gluten allergy, they do have gluten free bread, hot dog buns, and pasta. Staff #70 admitted that they forgot to do that yesterday with the menu. The Dietary Supervisor stated it definitely upsets them if they do receive items that they are not supposed to. The CNA (Certified Nursing Assistant) informed the kitchen staff when such incidents happen. Staff #70 stated that he then talks to the residents individually to make sure they are being accommodated. An interview with a Certified Nursing Assistant (CNA/staff #156) was conducted on October 2, 2024 at 1:53 p. m. Staff #156 stated that reports or meal ticket indicate a resident's dietary restrictions and allergies. According to the CNA information is also availiable on PCC (Point Click Care). Staff #156 stated that during meal pass, they check or verify if there is anything on the tray that the resident is allergic to. The CNA stated that residents have a sheet of the alternative meals and some of the residents can call in and they can assist in submitting their request. Staff #156 stated that it is up to the resident to call and ask for the alternative. The CNA stated that the menu is posted on the wall or given to residents upon request. Staff #156 stated that the alternate menu consisted of grilled cheese sandwich, PBJ (Peanut Butter & Jelly sandwich), soup, fruit, cottage cheese, and quesadilla. The CNA stated that the impact of residents not getting a menu that meets dietary restrictions or needs is refusing to eat which can affect the resident's health and weight loss. Staff #156 stated that to her knowledge she did not know of a resident that had a gluten allergy. The CNA stated being familiar with resident #58. Staff #156 stated that resident #58 did not like the food in the facility and usually asks for Jell-O or pudding. The CNA stated that resident #58 would say how she does not like the food but believes that the resident does not eat it for a reason. Staff #156 stated not remembering if resident #58 had any dietary restrictions/allergies. (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	10/02/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with a Licensed Practical Nurse (LPN/staff #61) conducted on October 2, 2024 at 3:02 p. m., staff #61 stated that staff make effort to ensure that residents' dietary restriction or allergies are updated on the chart and notify the kitchen. The LPN stated that they communicate and report specific diet needs. Staff #61 stated that they are unaware of any resident that had a gluten restriction. The LPN stated that the staff should be familiar with residents' dietary restrictions or allergies since it could turn into something severe if a resident has an allergy or precaution. This can cause the resident to choke or aspirate. Staff #61 admitted that they are not familiar with the dietary alternate for residents with gluten allergy. According to the LPN an alternate menu that mainly consists of sandwiches would not meet dietary restriction or nutrition for someone that had a gluten allergy because a resident cannot eat sandwiches every day all day. Staff #61 stated that if there is not a good alternative meal for a resident with gluten allergy, they can have a decline in weight which can lead to malaise and fatigue. The LPN also stated that this would make the resident feel like they are being deprived. Lastly, staff #61 stated that a resident's gluten allergy should be indicated on the resident's nutrition assessment since that is a vital information pertaining to the resident's nutrition needs/restrictions. With regards to resident #58, the LPN stated that they were not aware of special diet or restrictions. An interview with the Director of Nursing (DON/staff #62) was conducted on October 2, 2024 at 4:03 p.m. Staff #62 stated that her expectation is that staff members would put in the dietary restriction in the system and obtain an order from the provider. The DON stated that nutrition assessment was a question more appropriate for the dietitian/nutritionist. Staff #62 stated that it is her expectation that residents' dietary needs will be bet. Additionally, the DON stated that she expected that there would be food options for different diet need; and that, if sandwiches were the only option then it is not a viable one. Staff #62 stated that she was not sure if they were meeting resident #58's dietary needs. However, if the nutritional needs are not being met then the doctor should be contacted. DON stated that if she had a gluten allergy and sandwiches was her only option, she would not enjoy eating sandwiches all the time. Review of the facility policy titled Menus indicated that it is the policy of the facility to assure that menus are developed and prepared to meet the nutritional, religious, cultural, and ethnic needs while using established national guidelines. The facility policy titled Nutrition reviewed July 2024 noted that clinical evaluation for nutritional assessment may include relevant conditions and diagnoses. The policy further notes that care plan will be updated or revised as needed.

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	10/02/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on observations, staff interviews and policy review, the facility failed to ensure the areas used for preparing, cooking and serving food were cleaned and maintained sanitary in accordance with professional standards for food service safety. The deficient practice could result in foodborne illnesses among residents. Findings include: On September 30, 2024 at 10:51 a.m., an observation was conducted of the facility's kitchen with the dietary supervisor (staff #14). At this time, the stove and stacked oven was observed to have grease build-up and burned debris under and behind the stove and stacked oven. Also, there was burned debris on the metal shelf on the front side of the deep fryer. Crackers and an applesauce cup were observed on the floor in the dry storage room. During this observation, staff #14 stated that cleaning of the kitchen happens daily, reported that the expectation in the kitchen is proper hand hygiene to prevent foodborne illness, that also includes hair and beard covering. Temperature and cleaning logs for the month of September 2024 were requested for further review. The review revealed that temperature logs were completed with specific temperatures. The review also revealed that daily cleaning of the kitchen did not include initials of the completion of the task. On October 1, 2024 at 10:33AM, an observation was conducted of the facility's kitchen with the dietary supervisor (staff #14), cook (staff #123), and dietary aide (staff #11). At that time, yellow square slices were observed near a preparing sink, unattended, unwrapped, and undated appropriately. The preparation sink had darkened objects directly under the sink, near these [NAME] burnt like objects was a silver container that appeared to contain towels with darkened corners and spots present. On the floor near that sink, red circular was observed. When asked, staff #123 stated that hamburgers with tomatoes and cheese, french fries and a pasta salad will be prepared for lunch. What appeared to be already prepared food and observed without dates on them. When asked, staff #11 reported that the observed food were individually wrapped peanut butter and jelly sandwiches, that they will be put in the nutrition fridges on the unit for overnight, and that they do not require a date on them. Collected hardened ice was observed running down the side of the wall in the kitchen refrigerator, as well as additional hardened ice collecting on the floor of the refrigerator, directly under a pipe. Moreover, cooking and baking sheet pans stacked on top of each other were observed with a wet like substance in between the stacked pans and deep baking sheets. The wall directly behind the stacked cooking and baking pens appeared to be exposed, as evidenced by chipped wall paint, directly behind the stacked and stored pans and deep sheets. An opened brown bag filled with a powder substance was also observed near the preparation station. A brown powdery substance was observed in the dry storage directly under containers that contained what appeared to be brown. [NAME] string like substances were observed on the corner of the metal stand holding items in the dry storage. (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	10/02/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Later that day at 12:12PM, the tray line was observed. Six residents out of the 19 (Resident #17 with a mechanical diet was given a regular diet, resident #65 with a mechanical diet was given a regular diet, resident #394 with a mechanical soft diet was provided regular diet, resident #7 was provided an item that was stated as a dislike, resident #62 with a mechanical soft diet was provided a regular diet, and resident #49 was provided an item that they stated a dislike) were provided items that were not listed on their meal tickets and/or provided meal items that are not in accordance to the diet provided on the meal ticket. Staff #123 also reported that in the event of a non-gluten diet, resident's receive items such as non-gluten pasta and non-gluten bread. In regards to diet type, Staff #123 reported that in the event of a mechanical soft diet, a resident will be provided grounded up meat, grounded up pasta, and grounded up tater tots, to assist with eating. Staff #11 reported that diabetic diets will then receive fresh fruits for a regular diet or zero sugar jello for a mechanical soft diet in replacement of the desert on the menu. An interview on October 2, 2024 at approximately 12:40PM was completed with dietary manager (staff #14) to which they stated what their expectation with food storage, preparation, distributing and serving food is that staff is expected to complete the labeling and dating food, keeping the areas clean, washing their hands, and maintaining appropriate temperatures. Staff #14 stated that the risk of improper palpable temperatures can get people sick. Staff #14 also stated that for individuals with dietary restrictions, ie. Gluten or fish, providing residents with those dietary restrictions are not within professional standards and that they will attempt to provide non-gluten and try to substitute it with another protein for there is restrictions with fish. Staff stated forgetting to provide a gluten free option for the burgers and pasta salad on October 1, 2024; and that, forgetting the preferences of the resident's upsets their mood and their time here. Review of the kitchen policy titled, 'Sanitization of Dining and Food Service Areas', revealed that staff is responsible for all cleaning tasks and that staff will initial the tasks as they are completed. Review of the provided kitchen policies, which were policies titled, 'Dietary Policy', 'Code of Dress Code and Personal Appearance', 'Proper Handwashing and Glove Use', 'Nutrition', 'Resident/Personal Food Storage', and 'Sanitization of Dining and Food Service Areas', revealed no policy addressing personal preference of food options and diets, and as well as no policy addressing the execution of following established diets as stated on a resident's meal ticket.

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	10/02/2024

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on observations, staff interviews and policy review, the facility failed to adhere to infection control policies while serving, preparing, and distributing food to residents, and while providing care to one resident (#65). The deficient practices could result in foodborne illnesses among residents and the transmission of infection. -Regarding food preparation and distribution to residents: On September 30, 2024 at 10:51 a.m., an observation was conducted inside the facility's kitchen with the dietary supervisor (staff #14) who did not have a beard covering. At that time, staff #14 reported that the expectation in the kitchen is proper hand hygiene to prevent foodborne illness, that also includes hair and beard covering. On October 1, 2024 at 10:33AM, an observation was conducted of the facility's kitchen with the dietary supervisor (staff #14), cook (staff #123), and dietary aide (staff #11). At that time, staff #14 was observed without a beard covering. Staff #123 was observed at the sink rinsing their hands in prior to preparation of lunch, however soap was not used. During this observation, staff #14 reported that the expectation in the kitchen was proper hand hygiene to prevent foodborne illness; and that, includes hair and beard covering. Later, staff had put on a beard covering. On October 1, 2024 at 1:33PM, a test tray was brought into the conference room after being closely monitored and followed throughout the facility. The final temperatures of the food were as follows: Meat at 96.4 degrees Fahrenheit; Tater tots at 95.7 degrees Fahrenheit; Pasta salad at 75.6 degrees Fahrenheit; While Staff #11 was observed temping each food component, without sanitizing the temperature rod utilized by staff throughout the demonstration process. During this observation, staff #11 was interviewed regarding the palpability of the food, to which staff reported that the temperature of the food were not to professional standards, and, that the expectation of proper sanitization is to sanitize the temperature rod in-between temping food components. An interview on October 2, 2024 at approximately 12:40PM was conducted with dietary manager (staff #14) who stated that the expectation with food storage, preparation, distributing and serving food is that staff complete the labeling and dating food, keeping the areas clean, washing their hands, and maintaining clean hygiene, hair net, beard nets, gloves are used, masks are used when needed, typically when something is under the weather. (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	10/02/2024

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 - Some	51124 -Regarding Resident #65 Resident #65 was admitted into the facility on [DATE], with diagnoses that included metabolic encephalopathy, acute respiratory failure, end stage renal disease, cirrhosis of liver, hemiplegia and hemiparesis following cerebral infarction, and dysphagia. The admission minimum data set (MDS) assessment dated [DATE], revealed that the resident had a brief interview for mental status (BIMS) score of 3, which indicated was severely cognitively impaired. Moreover, assessment revealed that the resident had the presence of a feeding tube on admission and while a resident. Review of Resident #65's physician orders revealed an order dated July 10, 2024, for Enhanced Barrier Precautions (EBP): personal protective equipment required for high resident contact care activities, with an indication of indwelling medical device. Review of Resident #65's care plan initiated July 23, 2024, revealed the resident requires tube feeding due to a swallowing problem, with an intervention to use Enhanced Barrier Precautions (EBP). An observation conducted on October 01, 2024, at 9:48 AM, revealed a registered nurse, (RN/Staff #72) performed hand hygiene and donned gloves, but did not wear a gown, when entering the resident's room. The RN administered the resident's medications with a syringe into the resident's feeding tube. The feeding tube was flushed with water and cleaned with a sanitizing wipe. Staff #72 performed hand hygiene when leaving the resident's room. Directly after the observation of medication administration, an interview was conducted with Staff #72. When asked if Resident #65 is on any precautions, Staff #72 initially stated I don't think he is, then stated he is on Enhanced Barrier Precautions. When asked what EBP entails, Staff #72 stated I have to look it up, and was able to walk over to the resident's room to read the precautions sign posted on the resident's door. Staff #72 stated that EBP entails using hand sanitizer and wearing a gown and gloves when providing all hands-on resident care. Staff #72 then stated, I forgot to put my gown on. In an interview conducted on October 02, 2024 at 11:21 AM, the Director of Nursing (DON/ Staff #62) stated that for Enhanced Barrier Precautions, there is a sign posted outside the resident's door and posted above the resident's bed as well; and that, entails wearing a gown and gloves when providing direct care to residents. The DON stated that EBP is indicated for residents with catheters, indwelling medical devices, certain wounds, and residents with a history of multi-drug resistant organism infections. The DON stated that the importance of adhering to EBP is to prevent the spread of infections; and that, the risk when EBP is not followed would be that a resident could get an infection. Review of the facility's policy titled Infection Prevention and Control Program, revised July, 2023, revealed that the infection prevention and control program involved all disciplines and individuals and that facility personnel will conduct themselves in a way that minimizes the spread of infection. The facility will decide what measures and interventions should be applied in individual circumstances. (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	10/02/2024

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 - Some	Review of the kitchen policy titled, 'Dietary Policy', 'Code of Dress Code and Personal Appearance' revealed the employees will be enforced to use effective hair restraints, such as hair nets, hair bonnets, and beard guards to prevent contamination of food or food contact services.