

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, and review of facility documentation and policy, the facility failed to ensure that the Ombudsman was notified of the transfer/discharge for 3 of 4 sampled residents (#115, #118, & 110). The deficient practice could lead to notifications and pertinent information regarding the discharge/transfer not being provided. Findings include:</p> <p>-Resident #110 was admitted to the facility on [DATE] with diagnoses that included encounter for other orthopedic aftercare of right hip fracture, hemiplegia of the right dominant hand, failure to thrive, dementia, and type 2 diabetes mellitus.</p> <p>The care plan initiated on October 4, 2025, revealed a focus on failure to thrive, diabetes, high blood pressure, seizure, urinary tract infection, dementia, and anorexia. The goal would be for the resident to be free from complications related to infection. The interventions included to administer medications as ordered and to monitor and document for side effects and effectiveness; dietary consult for nutritional regimen and ongoing monitoring; monitor, document and report to medical doctor as needed any signs and symptoms: headache, visual problems, confusion, disorientation, lethargy, nausea, vomiting, irritability, seizure activity, decreased appetite, and difficulty breathing; and keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.</p> <p>Review of the clinical record revealed that a nurse practitioner was updated on Resident #110's status, the resident had a decreased by mouth intake at breakfast, lunch and with med pass; had a facial and eye twitching; the Resident was unable to follow commands; and the Resident's vital signs were, blood pressure of 118/57, heart rate of 112, and respiratory rate of 24. Resident #110's family member was at bedside, and the family member requested Resident #110 to be transported to the emergency room. Resident #110 was sent out to the hospital on October 11, 2025.</p> <p>There was no evidence found in the clinical record and facility documentation that the Ombudsman was notified of the resident's transfer to the hospital.</p> <p>-Resident #115 was admitted to the facility on [DATE] with diagnoses of dysphagia, dysarthria, cerebral edema chronic ischemic heart disease, atrial septal defect, type 2 diabetes mellitus, atherosclerotic heart disease, parkinsonism, gout, and spinal stenosis.</p> <p>Review of the Order Summary Report revealed a physician order dated June 30, 2025 indicating that the resident may discharge home with remaining narcotics.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 035131	If continuation sheet Page 1 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Discharge Summary and Post-Discharge Plan of Care dated June 30, 2025 documented a planned discharge scheduled for July 1, 2025.</p> <p>A Discharge Summary & Nursing note dated June 30, 2025 documented that the resident was given instructions for ongoing care, information on community resources, and patient advocacy.</p> <p>Furthermore, review of the resident's signed Transfer/Discharge Report dated July 1, 2025 revealed that it included an inventory of resident's personal effects, list of medications, and medication prescriptions.</p> <p>Review of the resident's face sheet revealed that he is his own financial responsible party. Additionally, the face sheet indicated the resident's wife as his emergency contact and listed her contact information. Additionally, the face sheet noted that the resident was discharged home on July 1, 2025.</p> <p>A discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the reason for the assessment as discharge & return not anticipated. The MDS indicated that the resident was discharged to home/community. Per the assessment the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating that he was cognitively intact.</p> <p>Further review of the resident's clinical record did not reveal any documentation of ombudsman notification regarding the discharge.</p> <p>Additionally, there was no facility documentation available regarding ombudsman notification.</p> <p>-Resident #118 was admitted to the facility on [DATE] with diagnoses that included paroxysmal atrial fibrillation, neuropathy, and morbid obesity.</p> <p>A Discharge Summary & Nursing note dated December 22, 2025 documented that the resident was given instructions for ongoing care, information on community resources, and patient advocacy.</p> <p>The Order Summary Report revealed a physician order dated December 23, 2025 for the resident to discharge home on December 24, 2025.</p> <p>Review of the resident's face sheet revealed that the resident was her own financial responsible party. The face sheet indicated the resident's friend was her emergency contact and listed the friend's contact information. Additionally, the face sheet noted that the resident was discharged to home on December 24, 2025.</p> <p>The discharge Minimum Data Set (MDS) assessment dated [DATE] revealed that the reason for the assessment was discharge & return not anticipated. The MDS indicated that it was a planned discharge to home/community. Additionally, the MDS noted a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact.</p> <p>Furthermore, review of the resident's signed Transfer/Discharge Report dated December 24, 2025 revealed that it included an inventory of resident's personal effects, list of medications, and medication prescriptions.</p> <p>Further review of the resident's clinical record did not reveal any documentation of ombudsman</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>notification regarding the discharge.</p> <p>Additionally, there was no facility documentation available regarding ombudsman notification.</p> <p>An email correspondence with the Ombudsman office dated January 5, 2026 stated that they have not received discharge notices since June 2024.</p> <p>An email correspondence with the Director of Nursing (DON/staff #48) dated January 6, 2026 annotated that notification to ombudsman is verbal and occurs during ombudsman visits.</p> <p>An interview with the Social Services Manager (SS Mgr/staff #108) was conducted on January 6, 2026 at 12:15 p.m. Staff #108 admitted that when it came to ombudsman notification, she failed to do it the right way. Staff #108 said that she was in communication with the ombudsman. According to staff #108 she has been made aware that she has to notify the ombudsman if someone discharges from long-term care. Staff #108 stated she assumes that the ombudsman is a resource for resident and might need it as resident discharges as to why it is important to notify the ombudsman of transfer/discharge. Staff #108 noted that she does not know how to answer what the impact of not notifying the ombudsman of transfer/discharge. Staff #108 admitted that she had not started notifying the ombudsman formally.</p> <p>An interview with the Director of Nursing (DON/staff #48) was conducted on January 6, 2026 at 5:59 p.m. The DON stated that her expectation is that Social Services notify the ombudsman of discharges. According to staff #48 the ombudsman participates in resident council and visits with the social worker but was not sure of the extent of their interaction. The DON noted that it is important to notify the ombudsman of transfer/discharge since the ombudsman is the advocate for the residents. Per the DON the impact of failure to notify the ombudsman of transfer/discharge is that the residents might not get the services or additional resource for them. The DON admitted that the facility did not know that the ombudsman notification had to be in writing.</p> <p>Review of the facility policy titled Discharge or Transfer revised June 2023 indicated that it was the facility's policy to provide the resident with a safe, organized, structured transfer and or discharge.</p> <p>Further review of the facility's policy for discharge/transfer did not reveal that it addressed transfer/discharge notification to resident/resident representative. Additionally, the policy did not indicate what the required information are that is to be provided to the resident/resident representative. Furthermore, the policy did not state that the ombudsman would be notified of transfer/discharge.</p> <p>Per the State Operations Manual Appendix PP, revision 232, the facility must notify in writing the resident and the resident's representative of the transfer/discharge which includes the following items:</p> <p>The reason for the transfer or discharge;</p> <p>The effective date of the transfer or discharge;</p> <p>The location to which the resident is transferred or discharged</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A statement of the resident's appeal rights including the name, address and telephone number of the entity which receives the request, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request</p> <p>The name, address and telephone number of the Office of the State Long-Term Care Ombudsman</p> <p>The contact information for the agency responsible for the protection and advocacy of individual with developmental disabilities (if applicable)</p> <p>The contact information for the agency responsible for the protection and advocacy of individual with mental disorder (if applicable)</p> <p>Additionally, the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and facility policy review, the facility failed to ensure that medications were not left at the bedside for two residents (#62 and #121). Census was 100. The deficient practice could result in harm to the residents and/or visitors who have access to medications.-Resident #121 was admitted to the facility on [DATE], with diagnoses that included pneumonia (lung infection), atrial fibrillation (irregular heart rate), hypertension (high blood pressure), and need for assistance with personal care.</p> <p>A review of order summary revealed an order dated December 31, 2025, for Metoprolol Tartrate oral tablet 25 MG (milligram) give half a tablet by mouth two times a day for high blood pressure, and an order for Saccharomyces Boulardii (probiotic) capsule 250 mg give 1 capsule by mouth two times a day for probiotic.</p> <p>The IDT (interdisciplinary team) - BIMS (Brief Interview for Mental Status) dated January 1, 2026 revealed a BIMS score of 14.0, indicating that the resident was cognitively intact.</p> <p>The Functional Performance Observation dated January 1, 2026, revealed that the Resident was independent with eating and oral hygiene, and mostly required supervision or touching assistance.</p> <p>The order for Metoprolol and Saccharomyces boulardii were transcribed onto the January 2026 Medication Administration Record (MAR).</p> <p>There was no evidence in the clinical record that the resident was assessed for self-administration or a physician order that the resident medications can be left at bedside for Resident #121 to self-administer at a later time.</p> <p>Review of the January 2026 MAR revealed that both of the medications were administered on January 4, 2026 at the 8:00 AM schedule.</p> <p>However, during an observation conducted on January 4, 2026, at 11:32 a.m., Resident #121's medications was left at her bedside table. When Resident #121 was about to take her pills, she knocked it over and the medicine cup flipped along with her 2 pills. She said that she was able to hold on to the white capsule which was her probiotic, but she could not find the tiny pill for her irregular heart rate. She said that she was not able to take her pills right away when the nurse gave it to her because she was on the phone with her brother, who was calling her from out of town.</p> <p>On June 4, 2026, at 11:38 AM, a certified nursing assistant (CNA/Staff #30) came into Resident #121's room. Resident #121 informed Staff #30 that the nurse brought her the medications, and she tipped it over. Staff #30 said that he will inform the nurse. At 11:42 AM, a Licensed Nursing Assistant (LNA/Staff #106) entered Resident #121's room. Resident informed Staff #106 that her medication cup flipped. Staff #106 stated to inform the nurse. At 11:48 AM, a Licensed Practical Nurse (LPN/Staff #90) entered Resident #121's room. Resident #121 informed the LPN that she did a bobo, Resident #121 said that she was going to take her pills but the medication cup went flying. The LPN stated that she will give her another pill. At 11:50 AM, the LPN returned in Resident #121's room. The LPN stated that she brought Resident #121's metoprolol 12.5 mg (milligram) pill. Then the LPN also stated that</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>she found the other pill, and it was dropped in the trash can. While the LPN was with Resident #121, Resident #121 stated dropped another one; Resident stated that the medication flipped out of her mouth. At 11:53 AM, the LPN left Resident #121's room and said to get another one.</p> <p>An interview was conducted on January 6, 2026, at 1:36 PM, with LPN (Staff #80) who stated that her role as a charge nurse included to support and oversee nursing staff. Regarding medication administration, she said that she would follow the medication direction to ensure that the right order, right dose, right route, right time, right medication were followed. The LPN said that she would then pull the medication, close her MAR, lock the medication cart, and walk into the resident's room; and, would tell and explain to the the resident what the medication was for. She said that she would then give the medication to the resident; and, observe the resident taking their medications to ensure it is taken appropriately. She said that she would not leave the medications at bedside because it was not their policy, unless there was an order to may leave at bedside. Further, she said that for her to leave a medication at bedside, there has to be an assessment called self-administration of medication. She stated that a potential bad outcome for leaving a medication at the resident's bedside include the resident may not take the medication, and if it was a heart medicine, for instance, their heart rate would not be controlled.</p> <p>The Director of Nursing (DON/Staff #48) was interviewed on January 6, 2026, at 2:12 PM. The DON stated that the process and expectation for medication administration was to have an order from the provider; and that, nurses administers the medication as ordered including the right time, right medication, right route, and right resident. The DON said that during a medication pass, the nurse introduces herself; informs the resident what medication they are getting and what it was for; and observe the resident swallow the medication. The DON stated that she would not leave the medication at the bedside. The DON said that the only time she would leave medications at bedside was when there is an order for it and the resident was alert and oriented. She also said that she would not leave the medication at bedside because it would place the resident and other residents at risk, and the risk depends on the type of medication. Further, the DON stated that the medications, Metoprolol and probiotic, for Resident #121 should not have been left at bedside because there was no order to leave at the bedside.</p> <p>-Resident #62 was admitted on [DATE], with diagnoses of acute posthemorrhagic anemia, atrial fibrillation, gastro-esophageal reflux disease (GERD) without esophagitis, and alcohol dependence.</p> <p>The care plan dated July 21, 2025, had a focused care area for Gastroesophageal Reflux Disease (GERD) related to medication use. Interventions included giving medications as ordered, monitoring/documenting side effects and effectiveness, and vital signs as ordered.</p> <p>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.</p> <p>The physician's order dated December 24, 2025, revealed orders for Calcium Carbonate (antacid) chewable 500 MG (milligram), give one tablet by mouth before meals for GERD without Esophagitis.</p> <p>Review of the medication administration record (MAR) for December 24, 2025, through December 31, 2025, revealed that Calcium Carbonate was administered to Resident #62 as ordered.</p> <p>Review of the physician orders from December 24, 2025, through January 4, 2026 revealed no physician order for resident #62 to self-administer Tums medications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MAR for January 1, 2026, through January 4, 2026, revealed that Calcium Carbonate was documented as administered as ordered.</p> <p>There was no evidence found in the clinical record that the resident was assessed for self-administration of prescribed medications from July 20, 2025 through January 4, 2026 at 9:36 a.m.</p> <p>An observation was conducted on January 04, 2026, at 9:36 a.m., Resident #62 was awake in her room, lying in her bed and watching television. There was a glass of water, a white, clear cup containing 3 pink circular pills. Resident #62 stated that the pills in the cup were her tums that she takes for her stomach issues; and that, the nurses leave them here for her to take when she needs them.</p> <p>In an interview with the Licensed Practical Nurse (LPN/staff #93) conducted on January 4, 2026, at 9:56 a.m., the LPN identified the medication as Tums and stated that these medications were usually left on the bedside table of Resident #62 for the resident to take by herself. She stated that she left the Tums at the resident's bedside today. She stated that the nurse would give the Tums to Resident #62 who usually took them right away; but that, today, the resident did not. She further stated that Resident #62 does not have a self-administration assessment and that medications should not be left at the bedside for Resident #62. However, the LPN stated that there was no risk associated with leaving Tums at the bedside.</p> <p>Shortly after the observation, the initial evaluation for Self-Administration of Medication was conducted and dated January 4, 2026, revealed that Resident #62 received the approval for self-administration. Assessment included that resident #62 can correctly state the name of the medication, what the medication is used for, state common side effects, state the time when it is supposed to be taken, was the medication is used for, proper dosage; and that, resident #62 was fully capable. The assessment also included that Resident #62 can be assisted with proper handwashing technique before and following medication administration, can correctly measure the appropriate amount of medication from the container, correctly document self-administration</p> <p>The physician's order dated January 4, 2026, included the resident may have Tums at the bedside.</p> <p>An interview was conducted on January 04, 2026, at 9:52 a.m. with a Certified Nurse Assistant (CNA/staff #95), who identified the medication as Tums and stated that no medication should be left at the bedside. She further stated that, as she was not a nurse and was unsure whether there was any risk associated with leaving the Tums at the bedside.</p> <p>An interview was conducted on January 5, 2026, at 2:19 p.m. with the Registered Nurse (RN/staff #76) who stated that no medication including Tums should be left at a resident's bedside unless there was a physician's order to do so. She further stated that if a resident has a physician order to self-administer Tums, the medication should be stored in an appropriate container. Further, the RN stated that leaving Tums at the bedside could pose a risk of medication interactions and electrolyte imbalance.</p> <p>During an interview with the Director of Nursing (DON/ Staff #48) conducted on January 6, 2026, at 2:13 p.m., the DON stated that no medication should be left at a resident's bedside unless the resident has a physician's order for medication self-administration. She stated that Tums may be left at the bedside if the resident was alert and oriented, understands the medication being taken and the reason for it, and has a physician's order to self-administer. She further stated that if there were multiple pills in a medication cup, they should be stored in an appropriate container. The DON</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated that leaving medications such as Tums at the bedside could pose a risk to the resident and/or other residents, as another individual could take the medication and potentially experience an allergic reaction. She further stated that leaving medication at the bedside without a physician's order would not meet the expectations of the facility or her own.</p> <p>Review of the facility policy titled Medication Access and Storage, E kit access last revised in June 2025 revealed that it is their policy to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.</p> <p>The facility policy titled Self Administration of Medications, last revised June 2023, revealed that it is their policy to respect the wishes of alert, competent residents to self-administer prescribed medications as allowable under state regulations. The purpose was to determine the ability of alert residents to participate in self-administration of medication and to maintain the safety and accuracy of medication administration. If a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. The residents cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. If the interdisciplinary team determines that this resident is unable to carry out this responsibility the interdisciplinary team may withdraw this right. If the resident is a candidate for self-administration of medications, this will be indicated in the chart. Resident will be instructed regarding proper administration of medication by the nurse. Nursing will be responsible for monitoring self-administered doses in the resident's medication administration record (eMAR). Storage and location of drug administration (e.g. resident's room, nurses' station, med cart, or activities room) will comply with state and federal requirements for medication storage.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, resident and staff interviews, facility documentation, and policy review, the facility failed to ensure that food items were palatable, and at a safe and appetizing temperature. The deficient practice could decrease residents' desire to eat which could impact their nutrition status and lead to slower recovery from illnesses or injury. Findings include: Review of the facility's 2025 Grievance log revealed the following food related grievances for the following months: January: general dietary/food concerns August: dietary concerns regarding temperature October: food preference issues (2 different residents) November: general dietary/food concern Review of the 2025 Resident Council Meeting Minutes documented the following food related issues brought up by attendees during the indicated month's meeting: January: concerns regarding menu variety February: concerns regarding food portions March: concerns regarding food portions April: concerns regarding food portions June: concerns with dietary restrictions July: indicated that residents were educated regarding proper food serving temperatures During screening interviews conducted with residents on January 4, 2026, multiple residents expressed to various surveyors that food was not appetizing because of temperature and taste. The following were resident comments regarding food: Resident #23 stated on January 4, 2026 at 9:21 a.m. that the food is shit and cold; Resident #20 said on January 4, 2026 at 9:40 a.m. that food is repetitive and not appealing; Resident #18 indicated on January 4, 2026 at 10:02 a.m. that her main concern is food because it does not look appealing. Additionally, the resident noted that food looks edible but most of the time, it is not; Resident #72 stated on January 4, 2026 at 10:18 a.m. that food sucks-not appealing; Resident #48 noted on January 4, 2026 at 12:25 p.m. that food is always cold and that he had constantly complained to staff about food; Resident #123 commented on January 4, 2026 at 2:02 p.m. that food is kind of yucky; and, Resident #73 said on January 4, 2026 at 3:51 p.m. that food is not good and always cold A lunch test tray was ordered on January 5, 2026 and arrived in the conference room at 12:46 p.m. The test tray sample consisted of fettucine alfredo with chicken, steamed broccoli, garlic breadstick, mashed potatoes and gravy. The items were temperature checked and the readings were as follows: Fettucine alfredo with chicken: 148.2 ? Fahrenheit Steamed broccoli: 152.3 ? Fahrenheit Mashed potatoes: 138.9 ? Fahrenheit Gravy: 158.8 ? Fahrenheit The portion size was adequate. However, the steamed broccoli was grayish-green in color, was bland, overcooked and mushy. The fettucine alfredo with chicken had the chicken pieces looked like tuna flakes. The garlic breadstick tasted stale. A group interview with residents which included resident council members was conducted on January 5, 2026 at 2:37 p.m. There were approximately 12 attendees; and, the following issues were voiced out the attendees: Food is unappealing and tasteless; Food is mushy and tasteless; When you ask for more they are told that the kitchen is out of that item; and, Double portions look the same as regular portion An interview with the Social Services Manager (staff #108) was conducted on January 6, 2026 at 12:15 p.m. Staff #108 stated that previously food concerns were trending during resident council meetings. However, the complaints pertaining to food had gone down. During an interview with the Dietary Supervisor (staff #39) conducted on January 6, 2026 at 3:02 p.m., staff #39 stated that dietary staff attends resident council meetings. Per staff #39 food concerns were normally brought up during resident council or via nursing staff from the resident; and that, whenever a food temperature issue comes up, she goes and temps the food served in the dining room and resident room. Staff #39 said that they had no complaint/s regarding the food not being appealing or appetizing. However, if she was to receive such a complaint, she would offer a substitute meal to the resident. Further, staff #39 said that it was important to provide food that is nutritious, appealing, and appetizing since it is what helps residents; and that, the impact of not having nutritious, appealing, and</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>appetizing meals is that residents would lose weight, wounds would not heal, and residents could get sick. An interview with a Certified Nursing Assistant (CNA/staff #91) was conducted on January 6, 2026 at 4:17 p.m. The CNA stated that residents have complained about food being cold; and, this was because there was not enough staff so food is not delivered on time. Additionally, she stated that residents had complained to her about food not being appetizing or appealing. During an interview with the Director of Nursing (DON/staff #48) conducted on January 6, 2026 at 5:59 p.m., the DON stated that her expectation was that food served to residents were edible, meet nutritional guidelines and portion, hot, and appropriate temperature. The DON stated that this was important so residents would eat and are provided nutritional intake; and, the impact of food not being nutritious, appealing and appetizing is that residents could lose weight, could suffer from adverse reaction if they have condition such as diabetes, and wounds could be created. In an interview with another CNA (staff #12) conducted on January 7, 2026 at 7:15 a.m., the CNA stated that residents have told her that food was not appealing or appetizing. The CNA indicated that when this occurs, then residents are asked if they want an alternative. Further, the CNA the potential impact of residents not being provided meals that are appealing/appetizing is that the residents would not get enough nutrients if they do not eat. This could lead to residents getting sick and their health declining. During an interview with a Licensed Practical Nurse (LPN/staff #69) conducted on January 7, 2026 at 7:50 a.m., staff #69 stated that residents have approached her with food concerns pertaining to the food not being appealing or appetizing. Per the LPN if the resident does not like the menu, she offers them an alternative as a substitute. According to the LPN if the resident is not provided appealing/appetizing meals then the resident might not receive the appropriate nutrition needed which could lead to deficiency. This could cause healing to be affected. Review of the undated facility policy titled Food Temperatures revealed that foods should be transported as quickly as possible to maintain temperatures for delivery and service. The facility policy titled Menus revised May 2022 indicated that it is the policy of the facility to assure that menus are developed and prepared to meet the nutritional needs of the residents and resident choices while using established national guidelines. Further review of the facility's policies pertaining to dietary/kitchen services did not reveal that it addressed food items being appetizing or appealing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, facility documentation, review of facility policies and procedures, the facility failed to ensure infection control standards/protocols related to Transmission Based Precautions (TBP) and hand hygiene were followed by staff. Census was 100. The deficient practice could result in the spread of infection to residents and staff. Findings include: -Regarding Hand Hygiene</p> <p>An observation of hall 100 was conducted on January 05, 2026, at 8:09 a.m. a certified nursing assistant (CNA/staff #55) went into a resident room [ROOM NUMBER] and took the Resident's breakfast tray and exited the room. The CNA then entered the another resident room [ROOM NUMBER] and touched the resident's bed and call light of the resident. The CNA exited room [ROOM NUMBER] and went directly into resident room [ROOM NUMBER]. The CNA did not perform hand hygiene before and after entering resident rooms and touching items found in the rooms.</p> <p>An interview was conducted on January 05, 2026, at 8:36 AM with the CNA (staff #55) who stated that hand hygiene should be performed before assisting with feeding, changing the resident's brief, performing catheter care, or going in and out of the resident room. She stated that she always washes her hands before she leaves any resident's room; and will perform hand hygiene after putting the resident's tray on the cart. She stated that it is important to perform hand hygiene because it will protect her and others from any sickness; and, if hand hygiene was not performed, it can pose a risk of cross-contamination and spreading sickness.</p> <p>Another observation in hall 200 was conducted on January 05, 2026 at 10:39 a.m. a staff entered a resident room, turned off the call light and exited the room without performing hand hygiene or used a hand sanitizer before and after entering the resident room.</p> <p>In another observation in hall 400 was conducted on January 05, 2026 at 10:43 a.m a staff entered and exited a resident room without performing hand hygiene or used a hand sanitizer.</p> <p>On January 5, 2026, at 1:51 p.m. an interview was conducted with a CNA (staff #13) who stated that staff must perform hand hygiene before entering and after leaving a resident's room. She said she uses hand sanitizer each time she goes in and out. She said that hand hygiene was important to prevent the spread of germs between staff and residents; and, not performing hand hygiene can lead to infections, such as flu or COVID-19, by spreading germs.</p> <p>An interview was conducted with a a Registered Nurse (RN/staff #76) on January 5, 2026, at 2:19 p.m. The RN stated that staff should clean their hands when entering and leaving a resident's room and use hand sanitizer each time. She said staff should wash their hands with soap and water if they are visibly dirty, such as when there is debris or body fluids on them. Further, she said that failing to perform hand hygiene can spread germs to residents and make others sick, so standard precautions must always be followed.</p> <p>During and interview with the Director of Nursing (DON/staff #48) conducted on January 6, 2026 at 2:13 p.m. the DON stated that staff were expected to wash their hands before and after providing patient care; and, if there was no direct patient contact, staff may use hand sanitizer. She said that staff must sanitize their hands after touching surfaces or resident belongings and before entering a resident's room; and, not performing hand hygiene increases the risk of infection transmission.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Regarding Following Transmission Based Precaution (TBP) Signage/Protocols</p> <p>During an observation conducted on January 4, 2026 at 9:45 a.m., there were two signs posted on the door of a resident room in the 100 hall: one sign indicated Enhanced Barrier Protection (EBP) and another sign indicated Contact Precaution. This room was occupied by 2 female residents. The sign posted for Contact Precaution included that staff must put gloves on and gown must be worn before entering the room and discarding the gown and gloves before exiting the room.</p> <p>Immediately following the observation, an interview with a Registered Nurse (RN/staff #58) was conducted on January 4, 2026 at 9:51 a.m. The RN stated that he does not know which precaution or TBP posting was to be followed for which resident in the room. The RN also said to ask Management for this information.</p> <p>On January 4, 2026 at 10:00 a.m., a staff member entered the same resident room in the 100 hall and provided the two female residents in the room hygiene supplies. Shortly after, another staff entered the room. Both staff did not have any PPE (Personal Protective Equipment) on and did not perform hand hygiene prior to entering the room.</p> <p>An interview with a Certified Nursing Assistant (CNA/staff #30) was conducted on January 4, 2026 at 10:04 a.m. The CNA stated the sign on the door which was on the left was intended for the resident in bed A; and, the sign on the right was for the resident in bed B. He said that the precaution signs posted on the door were meant to guide for staff; however, he did not know why the two residents in the room on the 100 hall were on precautions and did not believe the precautions applied to them. Therefore, he stated that the posted precaution signs for that room did not need to be followed.</p> <p>On January 4, 2026 at 10:08 a.m., the RN (staff #58) was removed both the EBP and Contact Precautions signs posted in the resident room in the 100 hall and placed both signs on top of the isolation cart located across the resident room in the 100 hall.</p> <p>An interview with the Infection Preventionist (IP/staff #103) was conducted on January 5, 2026 at 11:05 a.m. The IP stated that two residents with different TBP were not usually placed in the same room due to the risk of cross-contamination; however, if this occurs, the stricter TBP must be followed. The IP said that precaution signs were posted on resident doors to inform staff of the correct TBP to follow and that these precautions must be followed. She stated that signs were removed when they no longer apply or when a resident is discharged. She also said that staff, especially the nurse assigned to the resident, should know why a TBP sign was posted; and if they are unsure, they should contact her. She stated it is not appropriate to remove a sign without contacting her, as staff may miss important information about the resident's condition. The IP stated that the two residents in the room on the 100 hall were not supposed to be on TBP, and the signs should not have been posted. However, she said that since the signs were posted, staff should have followed the instructions until it was confirmed that they were not needed. She further stated that following TBP signage was important because a resident may have an infection; and, staff should be aware of the infections and TBP status of each assigned resident so they know what to monitor. The IP said that failure to follow TBP precautions could result in the spread of infection.</p> <p>During an interview with the Director of Nursing (DON/staff #48) conducted on January 6, 2026 at 5:59 p.m., the DON stated that her expectation was for staff to follow TBP signs posted in the resident room signage unless told otherwise; and that, she expected the nurse to know enough about infections and TBP related to the resident/s assigned to them. The DON also said that it was inappropriate</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Granite Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Scott Drive Prescott, AZ 86301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>for staff to be unfamiliar with resident assigned to them; and that, if staff were not familiar with TBP for their resident, the expectation was for staff to follow the precaution signs posted and to look into what was going on with that resident. She stated that it was important for staff to be familiar with residents in their care so that staff can monitor for adverse reaction. Further, the DON stated that she expected staff to follow standard precautions, hand hygiene and to follow the most stringent of the TBP if there were conflicting information. The DON said that following/implementing infection control standards was important to prevent infection and to protect not only the residents but the staff themselves; and, there is an increased potential for infection to spread if infection control protocols such as hand hygiene and TBP were not followed.</p> <p>Review of the facility policy titled Infection Prevention and Control Program revised/reviewed October 2024 stated that elements of the infection control prevention and control program included coordination/oversight, surveillance, outbreak management, prevention of infection, and employee health and safety. Additionally, the policy noted that the facility will decide what measures/interventions should be applied in individual circumstances.</p> <p>The facility policy titled IPCP (Infection Prevention and Control Program) Standard and Transmission-Based Precautions revised/reviewed October 2024 stated that it is their policy to implement infection control measures to prevent the spread of communicable diseases and conditions. The policy noted that they use and type of PPE (Personal Protective Equipment) is based on the predicted staff interaction with residents and the potential for exposure to blood, body fluids, or pathogens. Transmission-Based Precautions are the second tier of basic infection control and used in addition to Standard Precautions for patients who are or may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission.</p>		