STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record review, staff interviews, and review of policy and procedure, the facility failed to develop a complete baseline care plan that included the instructions needed to provide effective and person-centered care for one resident (#3). The deficient practice could result in resident care needs not being met. Findings include: Resident #3 was admitted on [DATE] with diagnosis including a displaced fracture of the left femur, pain in the left hip, hypertension, Alzheimer's disease, major depressive disorder, fibromyalgia, dementia, and heart disease. A review of the MDS (minimum data set) revealed a BIMS (brief interview of mental status) score of 11, indicating the resident had moderate cognitive impairment. A review of the baseline care plan initiated on June 17, 2024 revealed that resident #3 was noted to be a high fall risk and that the call light should be in reach, and that resident needs prompt responses to all requests for assistance, resident encouraged to wear appropriate footwear, occupational and physical therapy evaluations and treatment, cuing and supervision, bed lowered, mats on the floor by the bedside and initiation into the facilities falling star program for fall prevention and management. The care plan further noted that resident #3 had bladder incontinence; however, the care plan revealed no evidence of any interventions. An interview was conducted on June 24, 2024 at 1:46 P.M. with Social Services Director (SSD/staff #40). Staff #40 stated that the baseline care plan is generated from the nurse admission data collection. She stated that expectation, even for a baseline care plan, would be that interventions for each area of concern are noted. Staff #40 pulled up the care plan and stated that there were no interventions noted for bladder incontinence. She stated that the risk would include, not having the full picture of what the resident's needs are and if the needs and interventions are not properly identified, then staff would not know how to address them. An interview was conducted on June 24, 2024 at 2:18 P.M. with staff #35 LPN (licensed practical nurse). Staff #35 stated that the baseline care plan is conducted by nursing and does need to include the identified needs of the resident as well as the response or intervention to that need. (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
	035253	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on June 24, 2024 at 2:19 P.M. with staff #2 (ADON/Assistant director of nursing). Staff #2 reviewed the care plan and observed that area for bladder incontinence, he stated that this did not meet his expectations and that an intervention should have been noted for bladder incontinence. Staff #2 stated that the risk could include lack of oversight when it comes to falls, as well as a potential for skin related issues. He further stated that that it could be catastrophic for the resident if they are not being appropriately monitored due to lack of information in the care plan. A review of the facility policy entitled Interim Care Plan Policy with a revision date of February 2023 revealed that within 48 hours of admission a baseline care plan should be developed to include minimum healthcare information necessary to care for the resident's immediate health and safety needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 - Few	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** 47911 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that a resident was appropriately monitored post fall. The deficient practice could result in residents being injured. Findings include: Resident #3 was admitted on [DATE] with diagnosis including a displaced fracture of the left femur, pain in the left hip, hypertension, Alzheimer's disease, major depressive disorder, fibromyalgia, dementia, and heart disease. A review of the MDS (minimum data set) revealed a BIMS (brief interview of mental status) score of 11, suggesting moderate cognitive impairment. A review of the baseline care plan initiated on June 17, 2024 revealed that resident #3 was noted to be a high fall risk and that the call light should be in reach, and that resident needs prompt responses to all requests for assistance, resident encouraged to wear appropriate footwear, occupational and physical therapy evaluations and treatment, cuing and supervision, bed lowered, mats on the floor by the bedside and initiation into the facilities falling star program for fall prevention and management. The care plan further noted that resident #3 has bladder incontinence; however, the care plan revealed no evidence of any interventions for bladder incontinence. A review of the IDT (interdisciplinary team) note, entered by staff #12 RN (registered nurse) revealed an entry for June 19, 2024 noting that staff had responded to noise from the room of resident #3 and found the resident lying on the floor. The entry further noted that staff from the previous shift had reported that the resident had been attempting to transfer and ambulate on her own. It was further noted that as a result, staff were conducting frequent observations, redirecting the resident and were toileting the resident every 2-hours. It was documented that the resident was impulsive and had poor safety awareness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 - Few	An interview was conducted on June 24, 2024 at 12:01 P.M. with the daughter (individual #41) of resident #3. Individual #41 stated that on June 19, 2024 at about 6:15 P.M. she had gone to visit her mother. She stated that she had gone to her mother's room and the door to her room was open about 1.5 feet. She stated that a woman came from behind, entered the room and shut the door in the daughter's face. Individual #41 stated that she heard her mother crying and then opened the door and saw that her mother was on the floor. She stated that she asked staff if her mother had fallen and that she was told that she had. She stated that she had observed her mother lying on her side where she just had surgery and that she already had a pillow under her neck. The daughter stated that her mother shared she had to pee and that no one would come to help her. The daughter stated that a CNA (certified nursing assistant) had told her that she had taken resident #3 to the bathroom [ROOM NUMBER] to 13 minutes ago and that she observed her to be fine at that time. The daughter stated that all staff then left the room. She stated that no one was in the resident's room except for her, her husband and mother for about 5 minutes. Daughter stated that she was given no directions by staff, when they left the room. Daughter stated that she had a broken foot and was not able to provide much assistance, but did ask her mother if she would like another pillow. The daughter stated that resident #3 wanted the pillow. Once the pillow was provided, resident #3 pushed herself on her back. The daughter stated that once her mother was taken by the paramedics, none of the staff came back to the room to speak with her. She stated that she had to collect all of her mother's belongings on her own and then exited the building. The daughter came to the facility on [DATE] and showed this surveyor a video recording during the date and time of the incident. The observation of the video recording, revealed that the daughter and son-in-law were left alone with resident #3. Per the video recording, no observation was made that the resident or family members were instructed not to move the resident post fall. An interview was conducted on June 24, 2024 at 2:18 P.M. with staff #35 LPN (licensed practical nurse). Staff #35 stated that she was alerted by staff that resident #3 had fallen at about 6:15 P.M. She stated that she called the doctor while one staff member ensured that the resident was okay. Once the resident was assessed, she stated that one staff member called 911 and another was filling out the bed hold paperwork. She stated that the daughter was in the room with the resident, while staff were making the necessary calls and completing paperwork. She stated that when emergency medical services arrived the resident was still on the floor and that the resident had been left on the floor for a short amount of time without supervision. An interview was conducted on June24, 2024 at 1:30 with staff #15 (LPN). Staff #15 stated that the protocol for an unwitnessed fall includes assessing the resident for injuries, initiating neurological checks, calling the provider and conducting the applicable notifications. She stated that first staff have to ensure that the resident is safe, stay in the room with the resident until the resident can be safely moved or until emergency medical personnel arrive. She stated that she was not present when resident #3 fell . An interview was conducted on June 24, 2024 at 2:19 P.M. with staff #2 (ADON/Assistant director of nursing). Staff #2 stated that post fall, his expectation is that a staff member needs to be with the resident in the room as long as the resident is still on the floor. Staff #2 stated that the risk for not staying in the room with resident could include a worsening of condition, if the resident were to be moved. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 - Few	A telephonic interview was conducted on June 24, 2024 at 4:29 P.M. with staff #28 (LPN). Staff #28 stated that the resident was left alone in the room but only briefly as staff were going back and forth into the room. She stated that someone should have stayed in the room with her at all times. She stated that the fall had occurred in the middle of report/ shift change and that it was a very hectic time. She stated that the resident's initial neurological checks were fine. She further stated that there was a risk for leaving the resident on the floor without staff present, but did not indicate what the risk was. She further stated that she could not recall if anyone had informed the resident or family that the resident should not be moved. A review of the facility policy entitled Incident/ Accident Reporting with a revision date of October 2016 revealed that when a resident sustains a fall, that the extent and injury should be evaluated, health care provider notified and if an unwitnessed head trauma., the resident should be observed for neurological abnormalities. Neither Incident reporting or Falls Management Policy with a revision date of January 2024, provided instructions regarding direct observation and resident movement after a fall had occurred.