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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035253 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/22/2026 |
| NAME OF PROVIDER OR SUPPLIER Brookdale Santa Catalina | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure that one resident (#2) was properly transferred during a shower. The deficient practice could lead to serious injury. The Facility provided sufficient evidence that noncompliance was identified on March 27, 2026, and April 16, 2026 prior to the survey, and was in substantial compliance at the time of the survey for F0684. A QAPI meeting minutes revealed the original date identified was April 16, 2026, and the meeting was conducted on April 19, 2026, education provided by the facility revealed evidence of staff education/training. Past non compliance was identified. Findings include: Resident # 2 was admitted on [DATE] with diagnoses that included wedge compression fracture of 3rd lumbar, surgical aftercare, cauda equina syndrome, spinal stenosis, and need for assistance with personal care. A Care Plan initiated on April 10, 2026 revealed that Resident # 2 required assistance with bathing and showering. Further review of the Care Plan initiated on April 10, 2026 revealed that Resident # 2 has Activity of Daily Living (ADL) self care performance deficit. Interventions initiated on April 20, 2026 revealed that resident requires assistance with transfers with two people. Review of Resident Tasks revised April 14, 2026 revealed that Resident # 2 was 2 person maximum assist for transfer to the wheelchair. A Facility Investigation report dated April 22, 2026, revealed that a Certified Nursing Assistant (CNA/Staff # 79) transferred Resident # 2 from the recliner into the wheelchair and from the wheelchair to the shower chair. The report also revealed that after the shower Resident # 2 was transferred from the shower chair back to his wheel chair and that the resident was transferred back into bed. The investigation report revealed that Resident # 2 had a transfer status of 2 person assist and that CNA # 79 transferred the resident on his own. The investigation report also revealed that CNA # 79 confirmed that he had transferred Resident # 2 on his own using a gait belt. The report indicated that the resident's nephew reported to the facility social worker that Resident #2 had been treated poorly by a CNA who was rough with the resident during a shower. An interview was conducted on April 22, 2026 at 11:00 a.m. with Resident # 2 who stated that Staff # 79 came in to take him to get a shower. Resident # 2 stated that Staff # 79 picked him up from his recliner and transferred him to the wheelchair and wheeled him to the shower. Resident # 2 stated he was transferred again to the shower chair and when done was transferred back to wheel chair then taken to his room and transferred again by CNA # 79. Resident # 2 also stated that CNA # 79 was by himself and had no one to help him. Resident # 2 stated he was very rough with these transfers and it was painful. The Resident went on to say that the CNA never said anything to him while he continued with the shower. An interview was conducted on April 22, 2026 at 11:19 a.m. via phone with Licensed Practical Nurse (LPN/ Staff # 96) who stated that she worked with CNA # 79 on the night of April 16, 2026 into the morning of April 17, 2026. She stated that she received a complaint from Resident # 2 who told LPN # 96 that CNA # 79 was not 'caring' during his shower and was very fast with him. LPN # 96 stated that CNA was the only staff member present during the shower. LPN stated she talked to Resident # 2 and listened to his concerns. LPN # 96 stated that Resident # 2 did not want Staff #79 taking care of him and she assured Resident # 2 another CNA would take care of him the rest of the night. An attempt to contact CNA # 79 was made on April 22, 2026 at 11:35 a.m. but was unable to (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>make contact with CNA. An interview with CNA (Staff # 72) conducted on April 22, 2026 at 12:13 p.m. who stated that she knows if a resident is a 2 person assist by looking at the Kardex. CNA # 72 also stated that Resident # 2 is a 2 person assist and she usually gets the physical therapist to help transfer him into his wheel chair. CNA #72 also stated that if physical therapist is not available, she would get another person to help with the transfer. CNA # 72 stated that the risk of transferring Resident # 2 alone is that it could cause pain and injure the Resident. An interview with Regional Clinical Specialist (Staff #102), on April 22, 2026 at 12:59 p.m. revealed that it is her expectation that CNAs are to look at the Kardex to know if residents require 2-person assist during transfer. She also stated that if the Kardex says two person assist then her expectation is that two people are utilized to assist with transfers. Staff #102 stated that it was determined in their investigation that CNA #79 had transferred Resident #2 without any assistance. Staff #102 revealed the risk for not transferring Resident #2 with two people is that it could cause harm to the resident and the staff member. Review of the Policy titled, Supporting Activities of Daily Living, effective reviewed March 2026 revealed that residents who are unable to carry out ADLs independently should receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. The Policy also revealed that appropriate care and service should be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and/or resident representative and in accordance with the plan of care, including appropriate support and assistance with mobility which include transfer and ambulation, including walking.</p> | | |