STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** > Based on resident and staff interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services for the residents.Findings include: An interview was conducted with a certified nursing assistant (CNA/staff #29) on (MONTH) 11, 2019 at 9:40 a.m. Staff #29 stated that she was employed by a temporary nursing agency rather than by the facility. Staff #29 stated that it was her first day working at the facilty and that she was assigned to care for six residents. When asked how she knows how each resident should be transferred, staff #29 stated that she usually would ask the resident or other staff. Staff #29 further stated that she was usually able to assess whether or not a resident required one or two staff to assist with transfers. During an interview with a CNA (staff #30) on (MONTH) 11, 2019 at 9:45 a.m., staff #30 stated that she also was employed by a temporary nursing agency and it was her second day working at the facility. Staff #30 stated that most of the residents she was assigned to were able to transfer themselves but if she was unsure that she would ask another staff member. An interview was conducted with a licensed practical nurse (LPN/staff #31) on (MONTH) 11, 2019 at 9:50 a.m. Staff #31 stated she was employed by a temporary nursing agency and that she worked at the facility two days a week. Staff #31 stated that she watched the resident call lights and if she noticed that they weren't being answered timely that she would go to the resident room to see what was needed. Staff #31 further stated that she had not received any complaints about call light response time. An interview was conducted with a random resident on (MONTH) 11, 2019 at 10:00 a.m. The resident stated that staff try but sometimes she had to wait quite a while to have her call light answered. The resident stated that she had not received her morning medications yet and that she usually received them before breakfast. An interview was conducted with another random resident on (MONTH) 11, 2019 at 10:10 a.m. The resident stated that many upper management staff and nursing staff recently resigned and that the facility has been using a lot of agency staff recently. The resident stated that the facility is trying to resolve their staffing issues but two weeks ago she put her call light on because she had to urinate. The resident stated that her call light was on for an hour and forty minutes and she wet the bed. An interview was conducted with a CNA (staff #3) on (MONTH) 11, 2019 at 10:20 a.m. Staff #3 stated that there has not been enough staff at the facility for about three months. Staff #3 stated that the facility thought that two CNA's could care for 33 residents but there were a lot of residents who required two people to assist them with transfers. Staff #3 stated that CNA's have complained about the lack of staffing but nothing is done about it. Staff #3 stated that a lot of nurses recently quit. Staff #3 stated that a lot of times there is not enough staff to assist the residents with their showers. During an interview with a CNA (staff #7) on (MONTH) 11, 2019 at 10:50 a.m., staff #7 stated that the facility is short all the time. Staff #7 stated that the facility used to schedule 4 CNA's to care for 30 residents and now only scheduled 2 CNA's. Staff #7 stated that a lot of staff recently quit. Staff #7 stated that if staff call in they are not replaced. Staff #7 stated that the former director of nursing and assistant director of nursing used to help out but the agency nurses don't. Staff #7 stated a lot of nurses recently quit because they did not want to lose their license. Staff #7 stated that resident showers get postponed or missed a lot. An interview was conducted with a CNA (staff #4) on (MONTH) 11, 2019 at 11:00 a.m. Staff #4 stated that she had never seen staffing this bad. Staff #4 stated that it was too bad that the facility only scheduled 2 staff to care for 30 residents and that she felt bad for the residents. Staff #4 stated that there was not enough staff and everybody is quitting. Staff #4 stated that staff are sick and tired of working short handed. Staff #4 stated that showers don't always get done like they should and residents aren't getting their teeth brushed. Staff #4 stated you have no idea how awful the care for the residents is right now, it's sad. Staff #4 stated that's why the nurses quit, they didn't want to lose their licenses. Staff #4 further stated that all of the nurses working at the facility today were agency nurses and not employed by the facility. An observation was made in the dining room on (MONTH) 11, 2019 at 11:00 a.m. There was twelve residents in the dining room, two of whom required assistance with eating. One CNA was assigned to the dining room. An interview was conducted with the administrator (staff #32) on (MONTH) 11, 2019 at 1:00 p.m. Staff #32 provided an Agency Nurse Orientation Checklist signed by the two agency CNA's and the two agency LPN's who were working on this date. Although some of the staff worked at the facility prior to this date, all four checklists were signed and dated by the staff on (MONTH) 11, 2019. Staff #32 stated that the checklist was reviewed with the staff on the first day they worked at the facility but was not signed until today. An interview was conducted with a CNA (staff #29) on (MONTH) 11, 2019 at 1:05 p.m. Staff #29 stated that she was trained on the checklist in the morning but didn't know everything yet because it was her first day at the facility. Staff #29 stated that she was not aware of what the facility's emergency procedures were. An interview was conducted with an LPN (staff #31) on (MONTH) 11, 2019 at 1:10 p.m. Staff #31 stated that she just signed the Agency Nurse Orientation Checklist today but was trained on the checklist prior to this date. When asked what she would do in the event of a fire, staff #31 stated that she we ensure the residents were safe and get the fire extinguisher. When asked where the fire extinguisher was, staff #31 stated that she did not know but that she could go ask someone. An interview was conducted with the administrator (staff #32) and acting executive director (staff #33) on (MONTH) 11, 2019 at 1:30 p.m. Staff #32 and 33 stated that the facility is staffed based upon occupancy and resident acuity. Staff #32 and 33 stated that staffing declined in mid (MONTH) because of census and acuity and a lot of staff became disgruntled and upset. Staff #32 and 33 stated that corporate staff has been at the facility to help with staffing, Staff #32 and 33 stated that when there are 25 residents, 3 CNA's and 2 nurses are scheduled for first and second shifts. Staff #32 and 33 stated that 2 CNA's and 1 nurse are scheduled for third shift. Staff #32 and 33 stated that if there are only two CNA's scheduled for first and second shift because of the facility's inability to replace staff that the managers assist with resident care.An interview was conducted with a CNA (staff #24) on (MONTH) 11, 2019 at 1:45 p.m. Staff #24 stated Where do I begin, we are really short staffed. Staff #24 stated that for the last three weeks it has been very stressful because there have only been two CNA's to care for 32 residents. Staff #24 stated that a lot of the residents require two people to transfer them with mechanical lifts and then that leaves no one to care for the other residents during that time. Staff #24 stated that resident showers sometimes get delayed without enough staff. An interview was conducted with a CNA (staff #22) on (MONTH) 11, 2019 at 2:40 p.m. Staff #22 stated that a lot of the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) residents require two people to transfer them. Staff #22 stated that resident care is starting to decline without enough staff. A review of the Daily Associates Postings from (MONTH) 1 - 11, 2019 revealed seven days when there were only two CNA's scheduled for first and/or second shifts. Review of the facility's policy Resident Call system and Door Alarm Response documented Associates shall respond to resident call system alerts and door alarms in a reasonable and timely manner . The facility did not have a policy regarding staffing levels.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Post nurse staffing information every day.** > Based on observations, staff interview, and review of facility policies and procedures, the facility failed to post complete and accurate nurse staffing information on a daily basis. Findings include: Review of the Daily Associates Postings for (MONTH) 12, 24, 25, 26, and 27, 2019 revealed the posting was not completed regarding the total number and actual hours worked by registered nurses, licensed practical nurses, and certified nurse aides. Review of the Daily Associates Postings for (MONTH) 2, 3, 6, 7, 2019 revealed the posting was not completed regarding the total number and actual hours worked by registered nurses, licensed practical nurses, and certified nurse aides. Further review of the Daily Associates Postings for (MONTH) 2, 3, 9, 10, and 11, 2019 revealed the posting was not completed regarding the total number and actual hours worked by registered nurses, licensed practical nurses, and certified nurse aides. Review of the facility's Daily Associates Postings for the previous three months revealed none of the postings revealed the resident census on a daily basis. The Resident Census at Start of Shift was left blank on all of the postings. An interview was conducted with the interim director of nursing (staff #34) on (MONTH) 11, 2019 at 1:30 p.m. Staff #34 stated that a corporate staff member pointed out that the Daily Associates Postings were not being completed and that the facility was now doing audits to ensure the postings were completed accurately. Review of the facility's policy Benefits Improvement Protection Act Daily Associate Posting documented A daily schedule of licensed and unlicensed nursing associates who are responsible for resident care, will be posted in a prominent location, allowing associates, residents and visitors to view this information. The schedule will include the number and categories of nursing associates scheduled for each shift as well as the total number of hours worked .The designated associate member will post the community name, current date and resident census as well as the community specific shift schedule for a 24 hour period .