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	06/27/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (continued on next page)

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

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	06/27/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and facility policy review, the facility failed to ensure that medications were administered, stored and residents were assessed for self-administration of medication for one residents (#1). The deficient practice could result in medications not being administered according to physician's orders and medications not being stored safely.Findings include:Resident #1 was admitted to the facility on [DATE] with a diagnosis that included pneumonia, acute on chronic systolic (congestive) heart failure, hypertension, major depressive disorder, and urinary tract infection (UTI).Review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15.0, cognitively intact.During the survey's initial pool on June 24, 2025 at 10:55 AM, in Resident #1's room at the bedside table was a green covered top container which has Flonase label on it stored in a Ziplock bag and Resident stated that it is there to help him breath, he brought it with him, and it has always been on the table just in case he needed it.On June 24, 2025 at 11:03 AM, a Licensed Practical Nurse (LPN)/Staff #100 came in the room. Staff #100 stated that she did not know anything about the medications at bedside. She informed the resident that he is not supposed to have those in his room. Staff #100 identified the following item inside the ziplock bag as Flonase, lubricant eye drops, and Halls cough drops.Review of physician orders revealed an order for the following medications:- On June 24, 2025 at 11:15 AM, cough drops mouth/Throat lozenge 7.6 mg (milligram) give one drop by mouth every 3 hours as needed for cough and/or dry throat;- On June 24, 2025 at 11:15 AM, Artificial Tears Ophthalmic Solution 0.5-0.6 % (Polyvinyl Alcohol-Povidone (Ophthalmic), Instill 2 drop in both eyes every 4 hours as needed for dry eyes allergies; and - On June 24, 2025 at 11:15 AM, Flonase Allergy Relief Nasal Suspension 50 MCG/ACT (microgram/actuation) (Fluticasone Propionate (Nasal), 1 spray in both nostrils every 12 hours as needed for allergies.Review of care plan and progress notes revealed no self-administration of medication assessment documentation.An interview was conducted on June 25, 2025 at 9:21 AM with a LPN/Staff #60. Staff #60 stated that her role includes medication administration, wound care and catheter care. For medication administration, she compares the medication administration record (MAR) to the medication/bubble pack with the name and dosage of the medication. She verifies the resident's name. She stated that she would not leave medications at bedside because it is not safe, it can mess with the ordered medication time, and the resident can hide or store it and not take the medication. She stated that in some facilities, she is not familiar with this facility's policy, that some residents are allowed medications at bedside if it is specified in the physician's order. An interview was conducted on June 25, 2025 at 2:10 PM with the Director of Nursing (DON)/Staff #92. The DON stated that her staff administers medications and should never leave the medications at the bedside unless authorized. She stated that there is self-administration of medication that their residents can do. She stated that the process for self-administration of medication is they complete an assessment. If the resident is cognitively able to do so, the medications are safe at the bedside. She stated that residents should not have medications at bedside if the residents did not have self-administration assessment. Furthermore, the DON stated that if the resident or his or her family brought in the medication, and the resident or his or her family did not disclose of the medication to staff, the resident and his or her representatives will receive an education related to bringing medications from home, the staff will store the medication, and the staff will notify the provider to get an order for the medication. The DON stated that she was made aware of the medications left at bedside for Resident #1. The DON stated that the provider was notified of the medications, and that there was no self-administration of medication assessment completed because the resident did not disclose the medications to the staff. The DON stated that the risk of medications being left at bedside could interfere with other medications if taken inappropriately.Review of facility's policy titled, Resident Self-Administration of Medications, last revised on March 2019 revealed that residents who desire to self-administer medications may do so if the review determines the resident is capable. Policy detail: (3) The result of the Interdisciplinary Team (IDT) assessment is documented on the 'Self-Administration of Medications Data Collection form, which is placed in the medical record;(5) obtain health care provider's order that the resident may self-administer; and (6) the IDT shall develop and implement a care plan to monitor the resident's ongoing ability to self -administer medications.Review of facility's policy titled, Storage and Expiration Dating of Medications and Biologicals, last revised on August 1, 2024 revealed Procedure: (14) Facility should ensure resident medication and biological storage areas are

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	06/27/2025

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. (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	06/27/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, and facility policy, the facility failed to ensure one resident (#332) was free from preventable accidents including oral administration of Dakins solution. The sample size was 13. This deficient practice could result in an adverse event for the resident.Findings include:Resident #332 was admitted on [DATE] with diagnosis including acute and chronic respiratory failure with hypoxia, atrial fibrillation, hypertension, acute pulmonary edema, asthma, and dysphagia. A review of the 5-day MDS (minimum data set) dated April 14, 2025 revealed a BIMS (brief interview of mental status) score of 13, indicating that the resident was cognitively intact. A review of the progress notes revealed that on April 12, 2025 at 7:08 P.M. there was a noted in change in condition. It was documented that vitals taken April 11, 2025 between 9 and 10 P.M. showed an elevated systolic pressure reading of 147 while lying down, pulse, respirations and body temperature were noted to be in the normal range, blood sugars were elevated at 386. Additional documentation revealed that the resident stated that from now on she will drink from her pitcher instead of a cup. Primary care provider feedback noted to encourage the resident to drink plenty of water. It was further documented that the resident had no signs or symptoms of a swallowing disorder and no observed changes in mental of functional status.A progress note dated April 13 2025 revealed that the resident was alert and oriented. No noted pain or discomfort with chewing and swallowing and documentation indicating that the resident denied any gastro-intestinal symptoms.An order summary dated April 14/2025 revealed that the resident is to be monitored and that the physician is to be notified should the resident present with chest pain or tightness, lack of responsiveness, delirium (agitation and confusion), pain in the mouth or through burning, tearing and red eyes, burns to the esophagus-blistering, drooling or gagging sensation and low blood pressure.A review of the facility investigative report revealed that on April 12, 2025 at 2:30 P.M. licensed practical nurse (LPN/ Staff #61) had gathered all her supplies for treatment which included 1/2 strength Dakin's solution, utilized for wound treatment for another resident. It was documented that prior to doing treatment for the other resident, the LPN went into the room of resident #332 to administer her medications. It was noted that the supplies were placed on the medication cart and that the Dakin's solution was placed in a disposable drinking cup which the resident was handed instead of water. It was noted that the resident drank approximately 30 ml of the Dakin's solutions and reported to the LPN that it tasted weird. Staff #61 smelled it and realized that instead of water it was the Dakin's solution. It was noted that the LPN immediately gave the resident more water to drink. It was noted that the resident did not have any complaints of discomfort when swallowing. The provider was notified and staff were ordered to encourage more fluids. Both DON (director of nursing) and ED (executive director) were notified.Dakin's solution, per the NIH (National Institute of Health), National Library of Medicine, is a dilute solution of sodium hypochlorite, which is commonly known as household bleach. It further notes that when properly applied, it can kill pathogenic microorganisms with minimum cytotoxity.No observed evidence in the electronic health record that poison control had been contacted.An interview was conducted on June 25, 2025 at 10:56 A.M. with assistant director of nursing (ADON/ Staff #91) and the nurse practitioner, Staff #210. The ADON stated that nurses who pass meds also conduct the wound care.An interview was conducted June 25, 2025 at 12:14 P.M. with LPN, staff #87. Staff #87 stated that if a resident was administered an incorrect medication or substance, the first step would to identify the error and immediately report it to the DON (director of nursing) or the ADON and then the provider. Staff #87 stated that based on what was administered or ingested, the provider would render guidance on nest steps. The LPN stated that Dakin's solution is a topical used to treat wounds. Staff #87 stated that steps to avoid errors in adminstering medications and or other substances include double checking and taking care with what is provided to the resident.A telephone call was placed on June 25, 2025 at 12:30 P.M. to LPN/ Staff #61. A message was left on the voicemail requesting a call back. A secondary call was placed on June 25, 2025 at 12:50 P.M., the call again went to voicemail and another message was left. No return call received from staff #.A telephone call was placed to resident #332, the call was observed to go to voicemail. A message was left and no return call was received. An interview was conducted on June 25, 2025 at 2:03 P.M. with the DON/ Staff #92. Staff #92 stated that her expectation is for staff to only take those items into the resident rooms that are immediately needed and then to take out any items that were brought into the room after care had been completed. The DON stated that Dakin's solution should not be ingested. Staff #92 stated that she was familiar with the incident and stated