STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Yuma	2450 South 19th Avenue Yuma, AZ 85364

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199 Based on clinical record review, interviews and facility policy review, the facility failed to ensure their policy was followed for abuse and injury of unknown origin for three residents (#66, #54 and #89). The deficient practice could lead to other policies not being followed potentially placing residents at harm. Findings include: Resident #54 admitted to the facility on [DATE], with a diagnosis of dementia. Review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS)score of 03, which indicates severe cognitive impairment. Resident #66 admitted to the facility on [DATE] with a readmitted [DATE] and a diagnosis of sepsis and chronic pain. Review of the BIMS assessment dated [DATE], revealed a BIMS score of 15, indicating the resident was cognitive. The facility reported to the State Agency that a resident to resident altercation occurred between resident #66 and resident #54 on December 16, 2023. The allegation stated that resident #54 punched resident #66 in the back. Investigation by the state agency surveyor revealed that a thorough five day investigation from the facility had not been completed, residents clinical record had not been updated and the facility did not follow their own policy. There was no evidence to know what happened to this resident. Attempts were made for interviews but either no one remembered the incident, were no longer employed or no documentation could be provided. Resident #89 admitted to the facility on [DATE] with a diagnosis of periprosthetic fracture around internal prosthetic left knee joint and Alzheimer's disease. Review of the MDS dated [DATE] reveals a BIMS score of 05, indicating severe cognitive impairment. (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
	035133	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Yuma	2450 South 19th Avenue Yuma, AZ 85364

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported to the State Agency an allegation of neglect for resident #89 for an incident dated November 20, 2023. The complaint stated that at 10:00 AM a therapist entered her room and the resident stated she had left hip and groin pain. The therapist pulled the blanket back to look at the resident's leg and noticed there was a length discrepancy. It was then reported to the Director of Rehabilitation, who then reported to the Assistant Director of Nursing. Investigation by the state agency surveyor revealed that a thorough five day investigation from the facility had not been completed, residents clinical record had not been updated and the facility did not follow their own policy. There was no evidence to know what happened to this resident. Attempts were made for interviews but either no one remembered the incident, were no longer employed or no documentation could be provided. The facility's policy on Abuse, Neglect, and Exploitation, Chapter 3 page 1 has listed the Federal Regulations on 483.12 (c)(2) have evidence that all alleged violations are thoroughly investigated. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State Law, including he State Survey Agency, within 5 workings days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Yuma	2450 South 19th Avenue Yuma, AZ 85364

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199 Based on clinical record review, interviews and facility policy review, the facility failed to thoroughly investigate an injury of unknown origin and a resident to resident altercation for three residents (#66, #54 and #89). The deficient practice could lead to thorough investigations not being completed and sent to the State Agency potentially placing residents at harm. Findings include: Resident #54 admitted to the facility on [DATE], with a diagnosis of dementia. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS)score of 03, which indicates severe cognitive impairment. Resident #66 admitted to the facility on [DATE] with a readmitted [DATE] and a diagnosis of sepsis and chronic pain. Review of the BIMS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident is cognitive. The facility reported to the State Agency that a resident to resident altercation occurred between resident #66 and resident #54 on December 16, 2023. The allegation stated that resident #54 punched resident #66 in the back. Investigation by the state agency surveyor revealed that a thorough five day investigation from the facility had not been completed, residents clinical record had not been updated and the facility did not follow their own policy. There was no evidence to know what happened to this resident. Attempts were made for interviews but either no one remembered the incident, were no longer employed or no documentation could be provided. Resident #89 admitted to the facility on [DATE] with a diagnosis of periprosthetic fracture around internal prosthetic left knee joint and Alzheimer's disease. Review of the MDS dated [DATE] reveals a BIMS score of 05, indicating severe cognitive impairment. The facility reported to the State Agency an allegation of neglect for resident #89 for an incident dated November 20, 2023. The complaint stated that at 10:00 AM a therapist entered her room and the resident stated she had left hip and groin pain. The therapist pulled the blanket back to look at the resident's leg and noticed there was a length discrepancy. It was then reported to the Director of Rehabilitation, who then reported to the Assistant Director of Nursing. Investigation by the state agency surveyor revealed that a thorough five day investigation from the facility had not been completed, residents clinical record had not been updated and the facility did not follow their own policy. There was no evidence to know what happened to this resident. Attempts were made for interviews but either no one remembered the incident, were no longer employed or no documentation could be provided. The facility's policy on Abuse, Neglect, and Exploitation, Chapter 3 page 1 has listed the Federal Regulations on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Yuma	2450 South 19th Avenue Yuma, AZ 85364

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	483.12 (c)(2) have evidence that all alleged violations are thoroughly investigated. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State Law, including he State Survey Agency, within 5 workings days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Yuma	2450 South 19th Avenue Yuma, AZ 85364

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199 Based on clinical record review, interviews and facility policy review, the facility failed to ensure residents care plans were updated and revised on four residents (#15, #66, #54 and #89). The deficient practice could result in the medical records not being complete and accurate, resulting in the resident not receiving the proper care or interventions. Findings include: Resident #15 admitted to the facility on [DATE] with a diagnosis of Parkinson's Disease, repeated falls, tremors, difficulty walking and a history of falling. Review of the Minimum Date Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident is cognitive. It was reported to the State Agency that resident #15 sustained a fall that was witnessed by her roommate on December 17, 2023. It was reported to staff by the roommate, that resident #15 was standing by her bed and fell . Resident #15 told staff she had vertigo and fell . Review of the clinical record showed the care plan had not been updated after this incident. Resident # 54 admitted to the facility on [DATE], with a diagnosis of dementia. Review of the MDS dated [DATE] revealed a BIMS score of 03, which indicates severe cognitive impairment. Resident #66 admitted to the facility on [DATE] with a readmitted [DATE] and a diagnosis of sepsis and chronic pain. Review of the BIMS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident is cognitive. The facility reported to the State Agency that a resident to resident altercation occurred between resident #66 and resident #54 on December 16, 2023. The allegation stated that resident #54 punched resident #66 in the back. Investigation of this allegation showed no documentation in the clinic record of this. There was no evidence to know what happened to this resident. Attempts were made for interviews but either no one remembered the incident, were no longer employed or no documentation could be provided. Resident #89 admitted to the facility on [DATE] with a diagnosis of periprosthetic fracture around internal prosthetic left knee joint and Alzheimer's disease. Review of the MDS dated [DATE] reveals a BIMS score of 05, indicating severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Yuma	2450 South 19th Avenue Yuma, AZ 85364

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported to the State Agency an allegation of neglect for resident #89 for an incident dated November 20, 2023. The complaint stated that at 10:00 AM a therapist entered her room and the resident stated she had left hip and groin pain. The therapist pulled the blanket back to look at the resident's leg and noticed there was a length discrepancy. It was then reported to the Director of Rehabilitation, who then reported to the Assistant Director of Nursing. There was no evidence to know what happened to this resident. Attempts were made for interviews but either no one remembered the incident, were no longer employed or no documentation could be provided. Review of the care plans for residents #15, #66, #54 and #89 reveal the care plans were not updated after each incident. An interview was conducted on March 13, 2025 at 3:42 PM with the Director of Nursing (DON, staff #100) and the Assistant Director of Nursing (ADON, staff #50). They stated that if an incident occurred current practice would be to interview all parties involved, complete a skin assessment if needed, notify the responsible parties and the providers, update the care plan and have social services follow-up. This author had staff #100 to look over resident #66 and #54's care plans. She stated that neither care plan had been updated but since she was not DON at that time she could not answer why it wasn't updated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Yuma	2450 South 19th Avenue Yuma, AZ 85364

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199 Based on clinical record review, interviews and facility policy review, the facility failed to ensure accurate medical documentation was completed on four residents (#72, #54, #66 and #89). The deficient practice could result in the medical records not being complete and accurate. Findings include: Resident #72 was admitted to the facility on [DATE], from an out of state medical facility, with a diagnosis of chronic pain and chronic pain syndrome. Review of the resident Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15. This indicates that the resident is cognitive. An interview was conducted on March 13, 2025 at 12:10 PM with resident #72. She stated she had been admitted to the out of state medical facility with chronic pain. It was explained to her from the staff at the out of state medical facility, that the receiving facility would have the resident's controlled substances for her upon admission. Before discharge, the medical facility administered the resident a controlled substance so the resident would not experience pain during transport. A few hours after arrival to the receiving facility, the resident began to have pain. The staff offered Tylenol to the resident but the resident declined and requested to go to the emergency room (ER). An interview was conducted on March 13, 2025 at 12:42 PM with the Director of Nursing (DON, staff #100). She stated when a resident is admitting, they receive the discharge orders from the discharging facility and send any prescriptions to the pharmacy. If a resident has an order for a controlled substance, the pharmacy requires a handwritten prescription. Resident #72 did not have that prescription with her. Tylenol was offered but the resident refused and requested to go to the emergency room . The doctor in the ER wrote a prescription for the controlled substance and the resident returned with it. An interview was conducted on March 13, 2025 at 1:11 PM with Admissions Assistant (staff #25). She stated when a resident is accepted for admission she obtains the authorization from the insurance company and requests that the orders be faxed from the discharging facility. She states I spoke with the case manager from the discharging facility in the early morning of March 1, 2025 and asked for the orders to be faxed to me. I did not receive the orders until 3:13 PM that day and the resident arrived at 7:00 PM. Once I received the orders, I put them on our system called Tiger Text and the DON and the Medical Director see them. I was notified that there was an issue with some of the resident's medications and a handwritten prescription was required for some of those. I called the case manager at the discharging facility again, and told her we would need handwritten prescriptions for these particular medications. Her response to me was she couldn't send a handwritten one because the resident was going across a state line and that is prohibited for controlled substance medications. I relayed that information to the DON. Review of the medical record does not reveal any documentation regarding any of this. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Yuma	2450 South 19th Avenue Yuma, AZ 85364

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #54 admitted to the facility on [DATE], with a diagnosis of dementia. Review of the MDS dated [DATE] revealed a BIMS score of 03, which indicates severe cognitive impairment. Resident #66 admitted to the facility on [DATE] with a readmitted [DATE] and a diagnosis of sepsis and chronic pain. Review of the BIMS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident is cognitive. The facility reported to the State Agency that a resident to resident altercation occurred between resident #66 and resident #54 on December 16, 2023. The allegation stated that resident #54 punched resident #66 in the back. Investigation of this allegation showed no documentation in the clinic record of this. There was no evidence to know what happened to this resident. Attempts were made for interviews but either no one remembered the incident, were no longer employed or no documentation could be provided. Resident #89 admitted to the facility on [DATE] with a diagnosis of periprosthetic fracture around internal prosthetic left knee joint and Alzheimer's disease. Review of the MDS dated [DATE] reveals a BIMS score of 05, indicating severe cognitive impairment. The facility reported to the State Agency an allegation of neglect for resident #89 for an incident dated November 20, 2023. The complaint stated that at 10:00 AM a therapist entered her room and the resident stated she had left hip and groin pain. The therapist pulled the blanket back to look at the resident's leg and noticed there was a length discrepancy. It was then reported to the Director of Rehabilitation, who then reported to the Assistant Director of Nursing. Investigation of the allegation revealed there was no documentation in the clinical record. There was no evidence to know what happened to this resident. Attempts were made for interviews but either no one remembered the incident, were no longer employed or no documentation could be provided. The facility's policy on Abuse, Neglect and Exploitation, Chapter 3 dated October 13, 2023 page 2 states the facility must conduct record review for pertinent information related to the alleged violation, as appropriate, such as progress notes (Nurse, social services, physician, therapist, consultants as appropriate, etc), financial records, incident reports (if used), reports from hospital/emergency room records, laboratory or x-ray reports, medication administration records, photographic evidence, and reports from other investigatory agencies.