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	10/07/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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F 0609 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 review, interviews, and facility policy and procedure, the facility failed to ensure that an allegation of sexual abuse was reported to the State Agency within the required time frame for one resident (# 684). This deficient practice can result in allegations of abuse not being reported. Findings include:Resident #684 was admitted to the facility on [DATE], with diagnoses that include unspecified dementia, depression, unspecified, and paroxysmal atrial fibrillation. A review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. Further review of the MDS revealed that resident #684 was usually understood when communicating, but not without some difficulty.A review of the facility's Class Attendance Record, dated June 9, 2025, at 9:00 a.m., revealed that Incident and Reportable Event Management was presented to staff by the Director of Nursing (DON/Staff # 01).A review of the facility's Class Attendance Record, dated October 4, 2025, at 11:00 a.m., revealed that Abuse Identification Training was presented to staff by Staff # 01.Review of the facility's Abuse, Neglect, Exploitation (ANE) Allegation Investigation Checklist, revealed the event date was October 3, 2025, and the State Agency was notified October 4, 2025 at 8:43 a.m. An interview was conducted on October 7, 2025, at 11:28 a.m. with the Staff Development Coordinator (Staff #39). Staff #39 stated that staff are educated to report allegations of abuse to the designated abuse coordinator, who is expected to contact the appropriate authorities within two hours. Staff #39 further stated that the Director of Nursing (DON/Staff #1) was the designated abuse coordinator on October 3, 2025. Staff #39 revealed that the delay in reporting the allegation of abuse on that date was not in accordance with facility expectations or annual training.An interview was conducted with the Director of Nursing (DON/Staff #01) on October 7, 2025, at 12:30 p.m. During the interview, the DON stated that she was preparing to leave for a road trip but would remain accessible by phone if needed. The DON reported that she was alerted to the incident involving the allegation of sexual abuse on October 3, 2025, but did not report the incident until the following day. The DON acknowledged that she was aware that allegations of sexual abuse must be reported within a two-hour time frame but stated that she was not sure why she didn't call it in.An interview was conducted on October 8, 2025, at 9:40 a.m. with a Certified Nursing Assistant (CNA/Staff #7). The CNA stated that the allegation was initially reported to a Licensed Practical Nurse (LPN/Staff #20) at approximately 9:30 p.m. The CNA further stated that after reporting the allegation, Staff #5 was observed remaining on the hall with Resident #684. The CNA reported returning to the nurse around 10:00 p.m. to inquire why Staff #5 (the alleged perpetrator) was still in the facility and had not been removed from resident care areas.An interview was conducted on October 8, 2025, at 12:10 p.m. with Certified Nursing Assistant (CNA/Staff #5). The CNA stated that during his rounds, he was informed by the nurse (Staff #20) of an allegation of sexual abuse against him, prior to switching hall assignments on October 3, 2025, at 10:00 p.m. The CNA reported that he and Staff #20 discussed the resident's mental capacity and decided at that time not to move forward with reporting the allegation. Staff #5 and Staff #20 agreed that Staff #5 would no longer provide care to the resident. Staff #5 further stated that he felt nothing was wrong, as he was permitted to continue working for the remainder of his shift. Staff #5 also stated that he did not recall much about the facility's abuse prevention training but believed that the facility had 24 hours to report an allegation of abuse.An interview was conducted on October 8, 2025, at 12:42 p.m. with Licensed Practical Nurse (LPN/Staff #20). Staff #20 stated that she continuously heard the resident calling out for her parents during medication pass between 8:30 p.m. and 9:00 p.m. Staff #20 reported that while administering medications to Resident #684, the resident requested that she check her rectum because that man poked a hole in [my] rectum. Staff #20 stated that after calming the resident, she spoke with CNA/Staff #5 regarding the accusation and instructed him not to return to the resident's room for the remainder of the night. Approximately ten minutes later, Staff #7 informed Staff #20 of the same allegation of sexual abuse against Staff #5. Staff #20 stated that she directed CNA/Staff #7 to notify the Director of Nursing (DON/Staff #1) of the allegation. Staff #20 acknowledged that she was aware allegations of abuse are to be reported immediately to the DON but stated that she delayed making contact because she believed the accusation was a result of the resident's confused state.An interview was conducted on October 8, 2025, at 1:00 p.m. with Licensed Practical Nurse (LPN/Staff #34). Staff #34 stated that if there is an accusation of abuse, the facility's procedure is to immediately inform the Director of Nursing (DON) and ensure the resident's safety. The LPN also stated that

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 review, interviews, and review of facility documentation and policies, the facility failed to ensure that the facility policy was implemented regarding restricting access to residents following an allegation of abuse by a staff. This deficient practice placed the resident at risk and has the potential to violate the resident's right to safety and prevent further harm.Findings include:Resident #684 was admitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD), dementia, depression unspecified, and chronic diastolic (congestive) heart failure (CHF). A review of the Constipation related to decreased mobility care plan, initiated on November 10, 2023, revealed an intervention directing staff to encourage the resident to sit on the toilet to evacuate bowels, if possible.A review of the care plan focus area for Activity of Daily Living (ADL) Self-Care Performance Deficit, related to activity intolerance, fatigue, and impaired balance secondary to Chronic Obstructive Pulmonary Disease (COPD), emphysema, and Congestive Heart Failure (CHF), initiated on February 1, 2024, revealed that the resident was totally dependent on one staff member for personal hygiene and two staff members for toilet use.A review of the Risk for Bowel and Bladder Incontinence due to decreased mobility, decreased awareness of need, and overactive bladder care plan, initiated on March 26, 2024, revealed interventions directing staff to assist the resident with toileting as needed and to provide perineal care after each incontinent episode.A review of the hospice report, dated August 26, 2025, revealed that the resident requires maximum assistance with activities of daily living (ADLs), including bathing, dressing, and continence, and is incontinent of both bowel and bladder.A review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. Further review of the MDS revealed that resident #684 was usually understood when communicating, but not without some difficulty.A review of the facility's Abuse, Neglect, Exploitation (ANE) Allegation Investigation Checklist, revealed the event date was October 3, 2025. The checklist also revealed the Staff # 05 was placed on suspension October 4, 2025, at 8:39 a.m.A review of the staff assignment schedule dated October 3, 2025, revealed staff #05 was assigned to work the 400 hall 6p-6:15a, but was re-assigned to work the 500 hall after 10 pm. Further review of the assigned staff schedule sign-in sheet revealed staff #05's initials under the signature line on October 3, 2025. Review of the facility's staff #05's time card revealed a check-in time of 6:06 p.m. on October 3, 2025. The time card records Staff # 5'sbreak time of October 3, 2025, at 11:44 pm through October 4, 2025, at 12:16 a.m. Staff # 5 ended scheduled shift on October 4, 2025, at 6:02 a.m.A review of the alleged abuse incident report for October 3, 2025, at 11:00 p.m., revealed that the resident refused medical attention and that the accused staff member was removed from the resident's assignment and reassigned elsewhere. The report further indicated that Staff #05 was placed on suspension on October 4, 2025, at 8:30 a.m.A review of a provider progress note dated October 5, 2025, indicated that the provider was informed of the allegation by the resident, who described the incident as very painful. The provider noted no evidence of rectal or anal trauma, with no bleeding or erythema observed.A review of the Suspension Pending Investigation Form dated October 7, 2025, revealed that the abuse allegation was unsubstantiated and that the staff suspension was communicated via phone on October 4, 2025 (time not documented). Despite the unsubstantiated finding, the form indicated that Staff #05 was terminated due to quality of care concerns.A review of Staff # 5's Termination Form, dated October 7, 2025, revealed that upon interviewing multiple residents under the care of Staff # 5, there was a quality of care concern brought to the DON's attention. Many residents complained that Staff # 5 was rough when providing care and reported pain while he was performing peri-care. The reason for determination was for not upholding the facility's standards of care. The 5-day incident report revealed the CNA (Staff #07) contacted the Director of Nursing (DON) on October 3, 2025 at 11:15 p.m. to report the allegation. The report also supported that the DON gave instruction to have Staff # 05 removed from the hall, and have another staff member take care of resident #684 for the rest of the night. Further review of the 5-day incident report revealed the DON received a follow-up call from the LPN (Staff #20) at 8:20 a.m., and made the decision to suspend Staff #05 pending investigation.An interview was conducted on October 7, 2025 at 11:28 a.m. with the Staff Coordinator (RN/Staff #52) after review of this allegation, the coordinator revealed the correct course of action, was for the nurse to report the allegation to the abuse coordinator immediately, and for the alleged perpetrator to be immediately placed on suspension and sent home. The coordinator explained that the reason to immediately suspending the alleged perpetrator