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	12/17/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 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 record review, staff interviews, facility documentation and policy review, the facility failed to ensure controlled medications were recorded, stored, and reconciled accurately for one Resident (#1). The deficient practice could result in the inability to establishes a system of records of receipt and disposition of controlled drugs. Findings include:Resident #1 was admitted to the facility, with a last admission date of September 13, 2025, with diagnoses that included hypothyroidism, type 2 diabetes mellitus, anxiety disorder, chronic pain, acute on chronic systolic heart failure, and unspecified dementia.Review of the minimum data set (MDS) dated [DATE] revealed a brief interview mental status (BIMS) score of 08, which revealed Resident #1 had moderate cognitive impairment.A review of the care plan dated December 11, 2025 revealed that anxiety was addressed as a focus area. Interventions included administer anti-anxiety medications as ordered by physician.Review of the facility's 5-day investigation report submitted December 15, 2025, revealed that Licensed Practical Nurse (LPN) Staff #3 had a recollection of receiving the medication and placing it in the medication cart on September 16, 2025.An interview was conducted on December 16, 2025 at 10:04 pm with hospice registered nurse (RN) Staff #10 who revealed that the medications were delivered to the facility and the person accepting medication had signed a receipt for the controlled medication.A review of hospice documents was conducted on December 16, 2025 at 10:26 a.m. and revealed a receipt for Medication/Narcotic Delivery Receipt. Review of handwritten receipt revealed Staff #10 as person delivering medication: the name was printed, signature included, and there was a date, but no time. The persons who received the medication had Staff #3 printed, a signature, a time at 1735, and a date of September 16, 2025 at the bottom. Further, the receipts revealed the medications were Lorazepam 0.5 mg tablet with quantity of 60; Morphine: Solution 100/5 milliliter quantity 30.An interview was conducted on December 16, 2025 at 11:05 a.m. with LPN Staff #3 who revealed that on September 16, 2025, had singed for the medications. Staff #3 stated that the medication delivery had happened at the shift change and therefore the count verification was completed with the incoming nurse. Staff #3 stated that on September documented everything, however did not know when the Lorazepam went missing afterwards due to going on different hall after a few days. Staff #3 stated that both nurses and medication aids have access to the facility medication carts.An interview was conducted on December 16, 2025 at 11:33 a.m. with DON Staff #2 who revealed that a nurse may accept medications, however medication aides cannot sign for medications in the state of Arizona. Staff #2 stated that the process for medication orders from hospice was that hospice will fax over the orders to the facility's nursing station, and the nurse who is responsible for that hall, documents the medications. Staff #2 confirmed receiving a copy of the medication receipt by hospice after requesting the copy which was available for review. Staff #2 stated there was no order for the Lorazepam for Resident #1, prior to December 10, 2025 - despite the Lorazepam being added to the shift count on September 16, 2025. Staff #2 stated that everything was missing for the medication including the medication administration record (MAR) sheet. Staff #2 stated that a lot of staff members had access to the medications. Staff #2 stated that Approximately 10-15 nurses and medication aides had access to the medication cart since September 16, 2025. Staff #2 stated that policy required staff to count at the end of every shift; and that, it showed on September 16, 2025 that staff documented the addition correctly at the bottom Lorazepam and Morphine which noted to be added for Resident #1 on September 16.A review of documents from the facility was conducted on December 17, 2025 at 8:30 a.m. The Shift Change Controlled Substance Inventory Count Sheet. The first date was September 15, 2025 and the last was December 16, 0600. The first page was filled out with blank spaces, numbers written on top of other numbers. No second signatures. There are pages without a second signature for either On-Coming or Off-Going nurses. This occurred approximately 21 times. There were instances where both On-Coming and Off-Going had no signatures. A signature had a line drawn through it on December 1, Shift/Time 1800. The last page did not have the top portion filled out with Facility name. Unit had 600. The Date, # Containers/Cards and # Count Sheets were all blank. Change of Shift had the date of December 16 with Shift/Time 0600. Off-Going Signature noted and no On-Coming Signature, Start of Shift: Total # Cards/Cont. 20, Total # Count Sheets 22. There was a gap in the dates for the sheets. November 20 with Shift/Time 0600 on one page with signatures, Total # Cards/Cont. 18 and Total # Count Sheets 20. No additions or subtractions of medications was the last entry. The next page started on November 23, 2025 with Shift/Time 0600. The Off-Going had no signature and the On-Coming had a

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, staff interviews, facility documentation and policy review, the facility failed to ensure safe and secure storage of controlled medication for one Resident (#1). The deficient practice could result in unsafe handling of controlled medication.Findings include:Review of the facility's 5-day investigation report submitted December 15, 2025, revealed that Licensed Practical Nurse (LPN) Staff #3 had a recollection of receiving the medication and placing it in the medication cart on September 16, 2025.An interview was conducted on December 16, 2025 at 10:04 pm with hospice registered nurse (RN) Staff #10 who revealed that the medications were delivered to the facility and the person accepting medication had signed a receipt for the controlled medication.A review of hospice documents was conducted on December 16, 2025 at 10:26 a.m. and revealed a receipt for Medication/Narcotic Delivery Receipt. Review of handwritten receipt revealed Staff #10 as person delivering medication: the name was printed, signature included, and there was a date, but no time. The persons who received the medication had Staff #3 printed, a signature, a time at 1735, and a date of September 16, 2025 at the bottom. Further, the receipts revealed the medications were Lorazepam 0.5 mg tablet with quantity of 60; Morphine: Solution 100/5 milliliter quantity 30.An interview was conducted on December 16, 2025 at 11:05 a.m. with LPN Staff #3 who revealed that on September 16, 2025, had singed for the medications. Staff #3 stated that the medication delivery had happened at the shift change and therefore the count verification was completed with the incoming nurse. Staff #3 stated that on September documented everything, however did not know when the Lorazepam went missing afterwards due to going on different hall after a few days. Staff #3 stated that both nurses and medication aids have access to the facility medication carts.An interview was conducted on December 16, 2025 at 11:33 a.m. with DON Staff #2 who revealed that a nurse may accept medications, however medication aides cannot sign for medications in the state of Arizona. Staff #2 stated that the process for medication orders from hospice was that hospice will fax over the orders to the facility's nursing station, and the nurse who is responsible for that hall, documents the medications. Staff #2 confirmed receiving a copy of the medication receipt by hospice after requesting the copy which was available for review. Staff #2 stated there was no order for the Lorazepam for Resident #1, prior to December 10, 2025 - despite the Lorazepam being added to the shift count on September 16, 2025. Staff #2 stated that everything was missing for the medication including the medication administration record (MAR) sheet. Staff #2 stated that a lot of staff members had access to the medications. Staff #2 stated that Approximately 10-15 nurses and medication aides had access to the medication cart since September 16, 2025. Staff #2 stated that policy required staff to count at the end of every shift; and that, it showed on September 16, 2025 that staff documented the addition correctly at the bottom Lorazepam and Morphine which noted to be added for Resident #1 on September 16.A phone interview was conducted with DON Staff #2 on December 17, 2025 at 12:55 p.m. who revealed that at the beginning and end of each shift the On-Coming staff count with the Off-Going Staff the form was supposed to be filled out, but the staff are not filling it out completely; and that date with December 9, looked confusing and was unable to be explained. DON stated that a page was missing, and could not be found. DON stated that since finding out about the missing Lorazepam, education with the nursing staff has been conducted, the policy is that the count is done at shift change, and that the risk for not keeping accurate records is missing medications for residents and potential drug diversion situations.Review of facility's policy titled, Management of Controlled Substances, last revised: March 4, 2025 revealed the facility will maintain a system to account for controlled medications; receipt and disposition in sufficient detail to enable an accurate reconciliation, and that the facility conducts a periodic reconciliation. This system includes but is not limited to a record of receipt of all controlled medications with sufficient detail to allow reconciliation (e.g., specifying the name and strength of the medication, the quantity and date received, and the resident's name). Procedures 5. The facility will ensure that the incoming qualified individual and outgoing qualified individual count all controlled substances and other medications with a risk of abuse or diversion at the change of each shift and whenever control of the controlled substances changes from one qualified individual to another (e.g., associate leaves facility for lunch break), using the Shift Change Controlled Substance Inventory Count Sheet.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 record review, staff interviews, facility documentation and policy review, the facility failed to ensure medication records were completed, or safeguarded against loss or destruction. The deficient practice could lead to incomplete medical records in accordance to professional standards. Findings include:Resident #1 was admitted to the facility, with a last admission date of September 13, 2025, with diagnoses that included hypothyroidism, type 2 diabetes mellitus, anxiety disorder, chronic pain, acute on chronic systolic heart failure, and unspecified dementia.Review of the minimum data set (MDS) dated [DATE] revealed a brief interview mental status (BIMS) score of 08, which revealed Resident #1 had moderate cognitive impairment. 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