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	01/28/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interviews, and facility policy and procedures, the facility failed to ensure the care plan regarding anticoagulant therapy was established for one resident (Resident #9). The deficient practice may result in absence of person-centered goals or safeguarding against adverse events related to medication therapy.Findings include:Resident # 9 was initially admitted to the facility on [DATE], readmitted on [DATE], and had a medical history that included a history of falling, unspecified dementia, and unspecified anemia.Review of the MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 02, which indicated that Resident #9 was severely cognitively impaired. Section N titled, Medications - High-Risk Drug Classes, revealed Resident #9 was taking an anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin).A physician order dated December 28, 2023, revealed an order for Sodium Injection Solution Prefilled Syringe 40 milligram/0.4 milliliter of Enoxaparin Sodium to be given subcutaneously daily for deep vein thrombosis (DVT) prevention for 19 days. The start date was December 29, 2023 and end date were January 17, 2024.Despite Enoxaparin administered in the month of January, clinical records revealed no evidence of an anticoagulant therapy focus area in Resident #9's care plan report.Review of the medication administration records dated January 01, 2024 through January 31, 2024, revealed Enoxaparin was administered daily January 01 through 04, 2024 and January 09 through 22, 2024, in the abdomen subcutaneously.Review of the facility reported incident, dated January 5, 2024, the report described Resident #9 as highly impulsive, and sustained an unwitnessed fall while attempting to get out of bed. She was transferred to the hospital, where evaluation revealed a left hip fracture. The report indicated that the resident hit her head, and was receiving Enoxaparin Sodium therapy, which increased her risk of bleeding.An interview was conducted on January 28, 2026, at 10:10 a.m. with Certified Nurse Assistant (CNA/Staff #22). The CNA stated that staff refer to the resident's care plan to determine specific needs and interventions, when unfamiliar with a resident, the CNA will review the care plan to obtain additional information. The CNA stated staff must be extra careful with cares, because of prolonged bleeding blood thinners can cause. The CNA stated that residents on blood thinners may bruise easily, and should be monitored closely for things like urine in the blood. The CNA continued that checking a resident for bruising, and prolonged bleeding, is of utmost importance for residents on blood thinners.An interview was conducted on January 28, 2026, at 10:40 a.m. with Registered Nurse (Staff #54). The RN stated that fall-prevention education was provided during orientation and annually; and that, staff rely on the resident's care plan to identify resident-specific risks and interventions. The RN reviewed the clinical record and identified the resident's use of Enoxaparin Sodium to prevent DVT's, and stated that anticoagulant therapy required individualized care planning. The RN confirmed no care planning in the resident's record for anticoagulant therapy, and stated the absence of anticoagulant-specific care planning could limited (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff communication regarding monitoring and prevention of potential bleeding complications.An interview was conducted with a member of the Rehab Services team (Staff #10) on January 28, 2026, at 11:09 a.m. Staff # 10 stated that residents on anticoagulants are at higher risk for bleeding and bruising; and that, care plans should include monitoring for vital signs, symptoms, and blood loss, and departments working together to minimize fall risks.An interview was conducted with the Director of Nursing (DON/Staff #99) on January 6, 2026, at 11:34 a.m. The DON stated that care plans guide staff in implementing fall prevention interventions and educating staff on resident-specific risks, including anticoagulant therapy. The DON reported that staff obtain resident information through care plans, physician orders, and shift reports. The DON stated that care plans are expected to be reviewed and revised following any incident. The DON stated that review of the resident's clinical record did not identify care plan interventions addressing anticoagulant therapy for the resident who experienced a fall. The DON indicated this did not meet facility expectations because residents who are both fall risks and receiving anticoagulants are at increased risk for internal injury or bleeding following a fall.The policy titled, Area of Focus: Care Planning - Baseline, Comprehensive, and Routine Updates (Issued: 01/04/2022; Reviewed 12/04/2025), revealed Federal Regulation S483.21(b) requires the facility to develop and implement a comprehensive person-centered care plan for each resident. that includes measurable objectives and time frames to meet a residents medical nursing, and mental and psychosocial needs that are identified in the comprehensive assessment (MDS).The National Library of Medicine (updated October 26, 2022), revealed Enoxaparin is used to prevent and treat deep vein thrombosis (DVT; blood clots that form in the veins, typically in the legs). Enoxaparin is in a class of medications called low molecular weight heparins. It works by stopping the formation of substances that cause clots.The policy titled, Area of Focus: Anticoagulation Management (Issued: 01/03/2022; Reviewed 12/01/2025), revealed staff should ensure the care plan reflects anticoagulant use and is updated as needed.