

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Yuma		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff and resident interviews, review of facility documentation, and policy and procedures, the facility failed to protect the resident's right to be free from physical abuse by another resident for two of the four sampled residents (#2 and #3). The deficient practice could result in the resident being in an unsafe environment. Findings Include:- Regarding Resident #2: Resident #2 was admitted on [DATE], with a diagnosis of cerebral edema, dysphagia, aphasia, dysarthria, restlessness and agitation, stimulant abuse, hypertension, anemia, and repeated falls. An annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #2 was cognitively intact with no physical or verbal behaviors. A psychosocial note dated May 28, 2026, at 4:29 PM revealed that an assessment was conducted due to a physical altercation between Resident #2 and another female resident in the facility activity room. During the assessment, Resident #2 stated bumping into the wheelchair of another resident while in the activity room watching a film on television (TV), and the other resident was already upset with her and unsure of the reason and then other resident grabbed her hair and pulled it twice and she used her left arm to reach the back of head to get the Resident to let go her hair. This caused her finger to get hurt. The Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the Executive Director (ED) were made aware of the incident in a timely manner. A weekly skin integrity Data Collection dated May 28, 2026, at 5:45 PM revealed that Resident #2's left hand index finger nails were separated from the nail bed. A care plan was initiated on May 29, 2026, with a focus area for Resident #2 for mood problems related to an altercation with another resident. Interventions included that if the resident was noted to be in an altercation with Resident #3, staff would supervise, the resident would need time to talk, and the resident would be encouraged to express their feelings. An interview was conducted on July 07, 2026, at 2:47 AM with Resident #2, who stated that the other resident was mad and pulled on her hair twice and caused her pain. She also stated that at that time someone came to stop her from pulling the hair. - Regarding Resident #3: Resident #3 was admitted on [DATE], with a diagnosis of non-Hodgkin lymphoma, parlobular emphysema, hemiplegia and hemiparesis, anemia, hyperlipidemia, chronic viral hepatitis C, scoliosis, hypertension, chronic pain, and osteoarthritis. An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #3 was cognitively intact, with no physical or verbal behaviors. A psychosocial Note dated May 28, 2026, at 4:00 PM revealed that an assessment was conducted due to a physical altercation between Resident #3 and another female resident (Resident #2) in the activity room. Resident #3 explained that Resident #2 was in front of her wheelchair while watching the movie in the activity room. Resident #2 kept rolling back, hitting her leg, and was asked to move to the other side of the room, away from her. Resident #2 declined to move, touched her leg, (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was made on July 8, 2026 at 12:49 PM to Infection Preventionist (IP/Staff #10), but she was unreachable. An interview was conducted on July 08, 2025 at 1:15 PM with the ED (Abuse Coordinator/Staff #12), who stated that her role as abuse coordinator is that staff and residents know who she is, prevent abuse, investigate abuse, and report. She stated her number is posted at the nurses' station so anyone had access to her. She stated that when resident-to-resident abuse is reported to her, she would speak to the resident if they were able to be interviewed to get the story from them regarding what happened. She stated that if she was present on scene, she would separate them. She stated that the expectation of staff members when resident to resident altercation occurs is to separate the residents from each other, then they assess for any injuries, pain, psychosocial issues, and do a full assessment for both residents. She stated that the last time she received reporting on a physical resident-to-resident altercation was for Resident #2 and Resident #3 via phone. She stated that it was reported to her that Resident #2 accidentally bumped into Resident #3's chair or foot; it upset Resident #3, and then she pulled Resident #2's hair, and they were separated immediately. She further stated that a resident pulling another resident's hair would not meet facility expectations because it is physical abuse and all the residents' hands should be on themselves. A Policy titled Abuse & Neglect was revised November 19, 2024, revealing that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.		