STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035136	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Sierra Vista	2305 East Wilcox Drive Sierra Vista, AZ 85635

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, interview, and a complaint submitted via the State Agency's (SA) online complaint portal, the facility failed to ensure that resident #1's Power of Attorney (POA) was notified of the resident's hospitalization . The deficient practice prevented the POA from being informed of the resident's care and change in condition. Findings include: Resident #1 was admitted on [DATE] with diagnoses that included Dementia, malnutrition, and age-related cataract. Review of the quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) assessment was completed on February 16, 2024. The BIMS assessment revealed resident #1 scored a 06 which indicated the resident was severely cognitively impaired. The MDS also indicated resident #1 had no behavioral symptoms or falls since the prior quarterly assessment. A complaint was received, on February 14, 2025, via the SA complaint portal which indicated the resident was taken to the hospital due to a fall. The complaint indicated the POA was not notified of the hospitalization by the facility and did not find out about resident #1's fall until the hospital had contacted them. A review of resident #1's medical records did not reveal any documentation that the Power of Attorney or family member was notified of the resident's transport to the hospital. A review of progress notes revealed an entry dated March 18, 2024 at 5:30 AM which indicated the resident had woken up in the middle of the night due to complaining of shortness of breath but did not have a fever, cough, or sore throat. The note also indicated the physician ordered Zithromax (Z-pack) to be administered. The next progress note was entered on April 24, 2024 at 4:52 PM which indicated the resident was readmitted to the facility from the hospital and the resident had a right hip fracture. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 3, 2025 at 9:09 AM with Certified Nursing Assistant (CNA/Staff #13). Staff #13 explained that when a resident has a change in their condition they would notify the nurse on duty and the nurse would chart it in the resident's EHR. Staff added that CNAs only charted vitals and Activities of Daily Living (ADLs). When asked if a fall resulting in a resident being hospitalized would be considered a change in condition, staff #13 agreed that it was. When asked who would be notified of a resident's change in condition, staff #13 indicated that the nurse would let the resident's family and the doctor know. An interview was conducted on March 3, 2025 at 9:32 AM with Licensed Practical Nurse (LPN/Staff #57). Staff #57 explained that if a resident has a change in their condition, she would document it in a nurse's note in the progress note section (of the EHR) and she would notify the Director of Nursing (DON), the family if they had a Power of Attorney and the Doctor. Staff #57 also explained that if a resident had a fall which resulted in an injury, it would be considered a change in the resident's condition. Staff #57 added that she would document the notifications in a progress note in the resident's chart. Staff #57 indicated she was familiar with resident #1 and shared that she was working when resident #1 had a fall. She had heard the resident call out and saw that the resident was in the doorway of her room. She continued to explain that she assessed resident #1 and the resident was complaining of pain in the leg. Staff #57 also indicated that the doctor had told her to send the resident to the hospital for x-rays. When reviewing the resident's EHR with staff #57, staff #57 was not able to locate a progress note for the fall. Staff #57 was not able to explain why a progress note was not done, however she recalled that she notified the DON and the Doctor but didn't think resident #1 had any family members so no family notification was made. An interview was conducted on March 3, 2025 at 9:55 AM with LPN/Staff #26. Staff #26 explained that if a resident had a change in their condition which resulted in them needing to go to the hospital then she would document it in the resident's progress notes. She also indicated that she would inform the doctor, the resident's emergency contact, and the DON. Once the notifications were done, it would be documented in a progress note. Staff #26 shared that the risk of not notifying the emergency contact of the resident's change in condition and transfer would be the family not knowing what is going on with the resident. An interview was conducted with the DON/Staff #56 was conducted on March 3, 2025 at 10:13 AM. Staff #56 indicated that when a resident has a change in their condition, the nurses are to document the change in a progress note in the EHR. If there was a fall that was not their baseline and resulted in injuries, that would be a change in their condition. When staff #56 was asked to locate documentation in resident #1's EHR related to a change in her condition in April of 2024, staff was not able to locate anything related to a fall. When asked if the chart should tell her why resident #1 went to the hospital she stated, I would assume so. When staff #56 was referred to an attachment in the EHR that contained the hospital's discharge notes, staff #56 shared that the report indicated the resident had a witnessed fall and the resident had surgery on the hip per the surgical report. Staff #56 also shared that she looked up past incident reports and did not see anything related to resident #1's fall. Staff #56 was not able to determine if resident #1's family/POA was notified of the resident's hospitalization . She also shared that the risk of not notifying them would be a break in the change of communication or the family/POA might decide to visit the resident in the facility only to find out the resident was at the hospital instead and it might be hard on them. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Changes in Resident's Condition or Status, revised on September 5, 2024 indicated the facility will notify the resident representative of changes in the resident's condition or status. This also included when there is an accident involving the resident which results in injury, and when there is a decision to transfer . the resident from the facility .

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, interview, and a complaint submitted via the State Agency's (SA) online complaint portal, the facility failed to ensure that resident #1's electronic health record (EHR) contained accurate information about the resident's condition including changes in their condition. The deficient practice could prevent the resident from obtaining accurate services based on their medical condition. Findings include: Resident #1 was admitted on [DATE] with diagnoses that included Dementia, malnutrition, and age-related cataract. Review of the quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) assessment was completed on February 16, 2024. The BIMS assessment revealed resident #1 scored a 06 which indicated the resident was severely cognitively impaired. The MDS also indicated resident #1 had no behavioral symptoms or falls since the prior quarterly assessment. A complaint was received, on February 14, 2025, via the SA complaint portal which indicated the resident was taken to the hospital due to a fall. A review of resident #1's medical records did not reveal any documentation of a fall that took place in April 2024 which required the resident's transport to the hospital. A review of progress notes revealed an entry dated March 18, 2024 at 5:30 AM which indicated the resident had woken up in the middle of the night due to complaining of shortness of breath but did not have a fever, cough, or sore throat. The note also indicated the physician ordered Zithromax (Z-pack) to be administered. The next progress note was entered on April 24, 2024 at 4:52 PM which indicated the resident was readmitted to the facility from the hospital and the resident had a right hip fracture. An interview was conducted on March 3, 2025 at 9:09 AM with Certified Nursing Assistant (CNA/Staff #13). Staff #13 explained that when a resident has a change in their condition they would notify the nurse on duty and the nurse would chart it in the resident's EHR. Staff added that CNAs only charted vitals and Activities of Daily Living (ADLs). When asked if a fall resulting in a resident being hospitalized would be considered a change in condition, staff #13 agreed that it was. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 3, 2025 at 9:19 AM with CNA/Staff #20. Staff #20 shared that she was working the day that resident #1 had a fall. Staff #20 indicated that the fall had taken place in the doorway of resident #1's room and that it was not witnessed by staff. She also indicated that the physician was in the building at the time of the fall and he ordered the resident to be sent to the hospital. Staff #20 recalled that it had taken four or five staff members to assist the resident with getting off the floor. Staff also did not recall the exact date that the fall took place. When asked if a fall would be considered a change in the resident's condition and if it needed to be documented, staff #20 indicated that it would be a change in the resident's condition and the nurses would document it in the resident's chart. An interview was conducted on March 3, 2025 at 9:32 AM with Licensed Practical Nurse (LPN/Staff #57). Staff #57 explained that if a resident has a change in their condition, she would document it in a nurse's note in the progress note section (of the EHR) and she would notify the Director of Nursing (DON), the family if they had a Power of Attorney and the Doctor. Staff #57 also explained that if a resident had a fall which resulted in an injury, it would be considered a change in the resident's condition. Staff #57 added that she would document the notifications in a progress note in the resident's chart. Staff #57 indicated she was familiar with resident #1 and shared that she was working when resident #1 had a fall. She had heard the resident call out and saw that the resident was in the doorway of her room. She continued to explain that she assessed resident #1 and the resident was complaining of pain in the leg. Staff #57 also indicated that the doctor had told her to send the resident to the hospital for x-rays. When reviewing the resident's EHR with staff #57, staff #57 was not able to locate a progress note for the fall. Staff #57 was not able to explain why a progress note was not done. She indicated that she thought that she had completed the progress note. An interview was conducted with the DON/Staff #56 was conducted on March 3, 2025 at 10:13 AM. Staff #56 indicated that when a resident has a change in their condition, the nurses are to document the change in a progress note in the EHR. If there was a fall that was not their baseline and resulted in injuries, that would be a change in their condition. When staff #56 was asked to locate documentation in resident #1's EHR related to a change in her condition in April of 2024, staff was not able to locate anything related to a fall. When asked if the chart should tell her why resident #1 went to the hospital she stated, I would assume so. When staff #56 was referred to an attachment in the EHR that contained the hospital's discharge notes, staff #56 shared that the report indicated the resident had a witnessed fall and the resident had surgery on the hip per the surgical report. Staff #56 also shared that she looked up past incident reports and did not see anything related to resident #1's fall. Staff #56 shared that her expectation was for incidents to be documented in a timely and accurate fashion according to company policies and standards. Failure to do so would put them at risk of having an inaccurate representation of someone's care. Review of the facility's policy titled, Nursing Documentation, last revised on September 5, 2024 indicated that nursing documentation is to be consistent with professional standards of practice. The policy further stated that staff must document a resident's medical and non-medical status when any positive or negative condition change occurs . It also stated the medical record must contain an accurate representation of the actual experience of the resident.