

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2025
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Sierra Vista		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, interviews, and review of facility policies, the facility failed to ensure that medications were available as ordered for one resident (#100). The deficient practice could result in not receiving medications that are physician ordered and necessary.</p> <p>Findings include:</p> <p>Resident #100 was admitted to the facility on [DATE] with diagnoses that include Sepsis, weakness, chronic obstructive pulmonary disorder, asthma, anemia, endocarditis, hypothyroidism, hyperlipidemia, and hypertension.</p> <p>A review of the 5-day MDS (Minimum Data Set) dated January 7, 2025 noted the resident had a BIMS of 15, indicating no cognitive impairment.</p> <p>The care plan dated January 7, 2025 revealed the resident has a stage 1 pressure injury, with interventions including administer medications as ordered.</p> <p>The care plan dated January 7, 2025 also revealed the resident is at-risk for rehospitalization, with a noted intervention of staff to provide timely communication to physician's regarding any change in resident's condition.</p> <p>Review of the physician's orders dated January 3, 2025 showed an order for Ceftriaxone injection solution 2GM (grams) with instructions to give 2 grams intravenously in the evening for infection for a duration of 12 days.</p> <p>Review of the physician's orders also showed an order for Heparin lock flush solution 10 units/ml (milliliters) for PICC line flush with instructions to use 5 ml intravenously [NAME] 12 hours, indicating the line was patent and ready for use.</p> <p>However, a review of the MAR (Medication administration record) revealed that for the resident's stay, from October 3, 2025 to October 9, 2025 the resident received only 1 administration of Ceftriaxone on October 8th, 2025.</p> <p>Further record review revealed no evidence that the physician or pharmacy were notified that the medication was not available.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of progress notes dated January 4, 2025 at 7:54 p.m. revealed that the Ceftriaxone 2 gm was unavailable.</p> <p>A progress note dated January 5, 2025 at 9:47 p.m. revealed that the Ceftriaxone 2 gm was unavailable.</p> <p>A further review of progress notes revealed no additional notes on the status of the remaining administrations, including on January 7th 2025 where the documentation for the administration is blank, indicating that the medication was not given to the resident.</p> <p>Review of facility provided Omnicell items table list report dated March 14, 2025 included medications present in the facility for use. The list included 6 vials of Ceftriaxone 1 GM vial.</p> <p>However, while the list shows the medications were in the facility, they were not used in accordance with professional standards.</p> <p>A discharge progress note dated January 9, 2025 at 12:24 p.m. revealed the patient was noted to have a red non-raised rash to trunk and back, that the resident's skin color was grey and the patient complained of being cold and shivering. The note continued that the resident had a pulse of high pulse of 123, a low blood pressure of 88/55, and that they had contacted the on-call provider who gave instructions to send the resident to the hospital to be evaluated and treated. The note concluded that the emergency room staff had been given report to the resident's status indicating that the transfer was emergent.</p> <p>An interview conducted with a Licensed Practical Nurse (LPN/staff #30) on April 16, 2025 at 12:06 P.m., the LPN stated that new orders for IV antibiotics do not automatically go to the pharmacy and require the nurse to fax a set of orders to the pharmacy for them to be properly delivered. The nurse stated that for resident #100 that likely wasn't done and that's why the drugs were not available.</p> <p>An interview conducted with a Registered Nurse (RN/staff #40) on April 16, 2025 at 1:15 p.m., the RN stated that IV medications are ordered from the pharmacy when the nurses receive them, and have to be faxed over after they are received to be delivered correctly. The nurse further stated that the pharmacy will not deliver the drugs without faxing them unlike other medications.</p> <p>An interview was conducted on April 16, 2025 at 1:50 p.m. with the Director of nursing (DON/staff #50). During this interview the DON accessed the clinical record for resident #100. The DON confirmed the order for Ceftriaxone 2gm to administered once daily per the provider instructions, and stated the resident had only been given one dose for her entire stay in the facility. The DON stated that for IV medications the orders are put in the system, printed, and then faxed to the pharmacy who will then fill and send it. The DON stated that the resident was here for sepsis, and combined with the low BP and high pulse stated sounds like sepsis to me. The DON concluded that the medication not being given per provider instruction did not meet her expectations, and that resident #100 was transferred to the local hospital.</p> <p>A review of facility policy titled 'Administration of medications reviewed September 16, 2024 revealed The facility will ensure medications are administered safely and appropriately per physician's order to address residents' diagnoses and signs and symptoms.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record reviews, staff interviews, facility documentation, and facility policy, the facility failed to ensure one resident was free from preventable accidents including elopement. This deficient practice could result in preventable injuries as a result of elopement.</p> <p>Findings include:</p> <ul style="list-style-type: none"> <li>-Resident #200 was admitted to the facility on [DATE] with diagnoses that included abdominal aortic aneurism, diabetes mellitus type 2, dementia, and hypertension.</li> </ul> <p>A 5-day Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 03, indicating severe cognitive impairment.</p> <p>A care plan dated March 25, 2025 revealed resident #200 was at risk for elopement, with noted interventions of adding the resident to the elopement book for additional supervision, and encouraging the resident to participate in activities to divert from exit seeking behavior.</p> <p>An elopement assessment risk evaluation dated March 25, 2025 revealed staff had assessed the resident and found him to be an elopement risk and required additional supervision to divert from exit seeking behavior.</p> <p>A progress note dated March 27, 2025 at 1:33 p.m. revealed monitoring for exit seeking behavior, and noted 2 incidents of exit seeking behavior was observed.</p> <p>A progress note date March 28, 2025 at 10:49 a.m. revealed the patient had an elopement when he made his way from his room [ROOM NUMBER], ambulated to the front lobby and out the front door. Nobody attempted to stop the resident until the patient was outside and on the sidewalk. Multiple staff members made contact with the patient and helped to direct the patient back towards the front door of the facility. A CNA was next on scene to help escort resident #200 back inside the facility and to his room. The note concluded that resident #200 had been exit seeking all morning and is very impulsive.</p> <p>A progress note dated March 28, 2025 at 11:15 a.m. revealed that resident #200 had been observed wheeling around the facility and was last observed wheeling towards the main hallway in long term care. The note continues at 10:56 a.m. resident #200 had a repeated elopement out of the main hall west door. No alarms sounded from that door as it was unlocked on the inside. The gate facing north towards another business was also unlocked and ajar. The writer observed an empty wheelchair sitting halfway in the rocks outside. The writer continued that they made a quick visual sweep of any possible sightings before coming back inside the facility to alert staff that the resident had eloped again. Alerted the DON first at approximately 11:00 a.m. and code called overhead for elopement protocol. Multiple staff on foot checked immediate surroundings, facility sweep underway, and surrounding businesses checked by staff. The note concluded with a description of the resident's clothes and that the resident was ambulatory.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with a Licensed Practical Nurse (LPN staff/#30) on April 16, 2024 at 12:06 p.m. Staff #30 stated that resident #200 was identified as a flight risk from day 1. Staff #30 stated that he alerted the management the first day that resident #200 was too much of a wanderer and needed to get him out of the facility because he would get out. Staff #30 continued that his wandering behavior got worse as time went on, to include wandering into other peoples rooms, and that resident #200 required constant redirection. Staff #30 stated that after the second elopement he was placed on a 1:1 and given snacks and other things to help redirect him. Staff #30 stated that the first time resident #200 got out the front we heard on the intercom, rehab we need someone to the front two times, assuming it was a delivery because it wasn't called as an elopement. Staff #30 continued that while doing the medication pass, a CNA came and informed staff #30 that resident #200 had gotten out the front door. Staff #30 also stated that, all the managers were in a meeting and they had no idea, stating a manager even said later, That's what that page was for? indicating that it was not called an elopement on the overhead page. Staff #30 continued that the second incident resident #200 was in his wheelchair in the hallway, headed to therapy, got pulled aside for something else and when he returned to his cart was unable to find resident #200. Staff #30 stated that when they went out the back door, that the door was unlocked and the alarm was disabled, and the gate leading off the property outside that door was also ajar. Staff #30 stated they then called a code yellow and a sweep and search was initiated by several staff members. Staff #30 continued that resident #200 was found in a local grocery store by one of the CNA's, that they made multiple calls to surrounding businesses and the police. Staff #30 stated that while resident #200 was mobile, he had a 6.3cm triple A and the first question they had for the CNA was if the resident was alive, which he was. Staff #30 concluded that they were lucky and thankful it didn't rupture and after he returned to the facility they initiated a 1:1 for resident #200 until he left the facility, among other interventions.</p> <p>An interview was conducted with a Certified Nursing Assistant (CNA/staff #50) on April 16, at 1:34 p.m. The CNA stated that when resident #200 was reported missing, several of the staff went out and went around the grocery store parking lot looking for him. The CNA further stated that she got into her car and drove around looking for him in the area. They stated that when resident #200 got out he went out the back door and that one of the nurses found it unlocked. The CNA continued that when they were about to return to the facility, they decided to make a second sweep through the grocery store and that's when they located resident #200 inside. The CNA stated that resident #200 was found tired and wobbly, so they stated that one of the staff was left with him while she got a wheelchair and wheeled him back. The CNA concluded that when she got to the door resident #200 got out of the door was disarmed, green, and unlocked so that no alarm would go off.</p> <p>An interview was conducted with the Director of Nursing (DON staff/#50). The DON stated the day of the incident with resident #200 a nurse came to her office and stated resident #200 had gotten out. She stated that they both bolted up and headed out to find him. She stated that they had a strong suspicion because of the back gate being open, and the wheelchair being near the back door, and that it was a good clue the empty wheelchair that he got out that door. She further stated we made all our notifications to the police and others, and stated local PD was sending someone to help look for resident #200. The DON concluded that he was found nearby and was returned to the facility and placed on a 1:1 as they don't have a locked behavior unit, and that a performance improvement plan (PIP) was put in place to check doors and gates regularly as both were unlocked when the resident eloped.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of facility policy titled 'Missing residents / Actual Elopement' revealed the facility must develop and implement preparedness policies and procedures based on the emergency plan, and that the policies and procedures must be reviewed and updated at least annually. It further revealed that elopement occurs when a resident leaves the premises or a safe area without authorization (ie., An order for discharge) and or any necessary supervision. A situation where in which a resident with decision-making capacity leaves the facility intentionally generally not be considered an elopement, UNLESS the facility is unaware of the resident's departure and/or whereabouts.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, interviews, and review of facility policies, the facility failed to ensure that medications were available as ordered for one resident (#100). The deficient practice could result in not receiving medications that are physician ordered and necessary.</p> <p>Findings include:</p> <p>Resident #100 was admitted to the facility on [DATE] with diagnoses that include Sepsis, weakness, chronic obstructive pulmonary disorder, asthma, anemia, endocarditis, hypothyroidism, hyperlipidemia, and hypertension.</p> <p>A review of the 5-day MDS (Minimum Data Set) dated January 7, 2025 noted the resident had a BIMS of 15, indicating no cognitive impairment.</p> <p>The care plan dated January 7, 2025 revealed the resident has a stage 1 pressure injury, with interventions including administer medications as ordered.</p> <p>Review of the physician's orders dated January 3, 2025 showed an order for Ceftriaxone injection solution 2GM (grams) with instructions to give 2 grams intravenously in the evening for infection for a duration of 12 days.</p> <p>However, a review of the MAR (Medication administration record) revealed that for the resident's stay, from October 3, 2025 to October 9, 2025 the resident received only 1 administration of Ceftriaxone on October 8th, 2025.</p> <p>A review of progress notes dated January 4, 2025 at 7:54 p.m. revealed that the Ceftriaxone 2 gm was unavailable.</p> <p>A progress note dated January 5, 2025 at 9:47 p.m. revealed that the Ceftriaxone 2 gm was unavailable.</p> <p>A further review of progress notes revealed no additional notes on the status of the remaining administrations, including on January 7, 2025 where the documentation for the administration is blank, indicating that the medication was not given to the resident.</p> <p>Review of facility provided Omnicell items table list report dated March 14, 2025 included medications present in the facility for use. The list included 6 vials of Ceftriaxone 1 GM vial. However, while the list shows the medications were in the facility, they were not used in accordance with professional standards.</p> <p>An interview conducted with a Licensed Practical Nurse (LPN/staff #30) on April 16, 2025 at 12:06 P.m., the LPN stated that new orders for IV antibiotics do not automatically go to the pharmacy and require the nurse to fax a set of orders to the pharmacy for them to be properly delivered. The nurse stated that for resident #100 that likely wasn't done and that's why the drugs were not available.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted with a Registered Nurse (RN/staff #40) on April 16, 2025 at 1:15 p.m., the RN stated that IV medications are ordered from the pharmacy when the nurses receive them, and have to be faxed over after they are received to be delivered correctly. The nurse further stated that the pharmacy will not deliver the drugs without faxing them unlike other medications.</p> <p>An interview was conducted on October 20, 2023 at 11:29 a.m. with the Director of nursing (DON/staff #50). During this interview the DON accessed the clinical record for resident #100. The DON confirmed the order for Ceftriaxone 2gm to administered once daily per the provider instructions, and stated the resident had only been given one dose for her entire stay in the facility. The DON stated that for IV medications the orders are put in the system, printed, and then faxed to the pharmacy who will then fill and send it. The DON concluded that the medication was actually in their Omnicell, and that it did not meet her expectations that the medication was not provided.</p> <p>A review of facility policy titled 'Administration of medications' reviewed September 16, 2024 revealed that the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.</p>		