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	09/09/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 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 clinical record, staff interviews, review of facility documentation, policy and procedures and the State Agency (SA) database the facility failed to implement their policy regarding conducting thorough investigation of abuse/neglect allegation, protecting residents from further abuse for one resident (#46), and reporting allegations of abuse. The deficient practice could result in abuse/neglect continuing and not being prevented. Findings include: Resident #46 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of fatty liver, hypertension, and protein-calorie malnutrition. Review of resident #46's progress note dated March 26, 2025 revealed that the facility contacted another state agency regarding suspicion of financial exploitation involving the resident's frequent visitor (resident friend #666). Review of the SA database did not reveal any documentation that a self-report was submitted by the facility regarding the allegation of exploitation. However, the SA database revealed that another state agency reported an allegation of exploitation. A written request for a copy of incident report and facility investigation pertaining to resident #46 was submitted to the facility on September 7, 2025 at 1:40 p.m. An email response was received from the Executive Director (ED/staff #411) on September 7, 2025 at 2:07 which stated that there are no incident or investigations found. An interview with a Licensed Practical Nurse (LPN/staff #24) was conducted on September 9, 2025 at 4:18 a.m. Staff #24 stated that it is important for residents to not feel abused and implement abuse policy to ensure that residents' issue is not ignored and not treated poorly. The LPN said that if residents are abused then it can impact them poorly--lead to depression, feel unseen, and not heard as human beings. Staff #24 is unfamiliar with the exploitation issue concerning resident #46 and was not aware of any visitor restrictions. During an interview with a Certified Nursing Assistant (CNA/staff #101) conducted on September 9 2025 at 5:04 a.m., staff #101 stated that any type of abuse is reported to supervisor immediately so that it does not cause mental, physical, and emotional repercussions to the resident. The impact if it is not reported is that the resident can become anxious. The CNA noted that resident #46 can be confused at times but can definitely relay information. Staff #101 noted that she is unaware of any issues of exploitation regarding resident #46. An interview with the Social Services Assistant (SS Asst/staff #32) and the Social Services Director (SS Dir/staff #93) was conducted on September 9, 2025 at 10:02 a.m. Staff #93 noted that they found out about the exploitation was due to non-payment of cost share. The SS Dir said that resident friend #666 visited resident #46 and there was an allegation of financial. exploitation. During the course of the investigation, resident friend #666 was restricted from vising resident #46 per the previous administrator. An interview with the Assistant Director of Nursing (ADON/staff #90) was conducted on September 9, 2025 at 11:04 a.m. Staff #90 stated that his expectation is that any allegation of abuse is reported immediately to ensure that residents are protected. The ADON noted that it is important that residents are not exploited because nobody wants to see somebody taken advantage of-specially the residents who are a vulnerable group. According to staff #90 he remembered that there was a concern that resident #46 was being exploited by resident friend #666 but there were no specific details. There was picture of the resident friend #666 posted at the reception desk informing staff to not allow him in the facility. Another state agency was contacted involved. The ADON noted that he was unsure if the facility would do an investigation since they cannot easily do one on someone not affiliated with the facility. However, he said that exploitation is considered as abuse and that the facility investigates all allegation of abuse. Staff #90 said that the facility should have probably investigated in collaboration with the other state agency. Review of the facility policy titled Abuse - Identification of Types reviewed May 6, 2025 stated that the facility staff should report any suspected abuse, neglect, or exploitation to the Executive Director or Director of Nursing. The facility policy titled Area of Focus: Incident and Reportable Event Management reviewed November 25, 2024 noted that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property are reported immediately, but no later than 2-hours after the allegation is made. The policy also noted that all alleged violations are thoroughly investigated to prevent further abuse, neglect, exploitation or mistreatment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 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 closed record review, staff interviews, review of facility documentation, policy and procedures, the facility failed to report allegations of exploitation for one resident (#46) within the required timeframe. The deficient practice in abuse allegations not being reported and further abuse continuing. Findings include: Resident #46 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of fatty liver, hypertension, and protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has intact long term and short-term memory. An Alert Note dated March 26, 2025 documented that the facility contacted another state agency for suspicion of financial exploitation involving resident's frequent visitor (resident friend #666). However, further review of the resident's clinical record did not reveal any indication that the allegation of financial exploitation was reported to The State Agency (SA). Furthermore, review of the SA database did not reveal any documentation that a self-report was submitted by the facility regarding the allegation of exploitation. A cognition care plan that was initiated on August 29, 2025 revealed that the resident has mild cognitive impairment. Interventions included to cue, orient, and supervise resident as needed. Review of resident #46's care plan did not indicate any risk for exploitation. A written request for a copy of the incident report and the facility investigation pertaining to resident #46 was submitted to the facility on September 7, 2025 at 1:40 p.m. An email response was received from the Executive Director (ED/staff #411) on September 7, 2025 at 2:07 which stated that there are no incident or investigation found. An interview with a Licensed Practical Nurse (LPN/staff #24) was conducted on September 9, 2025 at 4:18 a.m. Staff #24 stated that allegations of abuse have to be reported immediately. According to the LPN, it is important for residents to not feel abused and implement abuse policy to ensure that residents' issue is not ignored. Staff #24 said that if residents are abused then it can impact them poorly--lead to depression, feel unseen, and not heard as human beings. Staff #24 is unfamiliar with the exploitation issue concerning resident #46. During an interview with a Certified Nursing Assistant (CNA/staff #101) conducted on September 9 2025 at 5:04 a.m., staff #101 stated that any type of abuse is reported to supervisor immediately so that it does not cause mental, physical, and emotional repercussions to the resident. The CNA noted that the report has to be done within 2-hours of the allegation. The impact if it is not reported is that the resident can become anxious. Staff #101 noted that she is unaware of any issues of exploitation regarding resident #46. An interview with the Social Services Assistant (SS Asst/staff #32) and the Social Services Director (SS Dir/staff #93) was conducted on September 9, 2025 at 10:02 a.m. Staff #93 noted that they found out about the exploitation was due to non-payment of cost share. The SS Dir said that resident friend #666 visited resident #46 and there was an allegation of financial. exploitation. According to staff #93, the other state agency investigated the allegation of financial exploitation. During the course of the investigation, resident friend #666 was restricted from vising resident #46 per the previous administrator. An interview with the Assistant Director of Nursing (ADON/staff #90) was conducted on September 9, 2025 at 11:04 a.m. Staff #90 stated that his expectation is that any allegation of abuse is reported immediately to ensure that residents are protected. The ADON noted that it is important that residents are not exploited because nobody wants to see somebody taken advantage of-specially the residents who are a vulnerable group. According to staff #90 he remembered that there was a concern that resident #46 was being exploited by resident friend #666 but there were no specific details. There was picture of the resident friend #666 posted at the reception desk informing staff to not allow him in the facility. Another state agency was contacted and investigated the allegation. The facility policy titled Area of Focus: Incident and Reportable Event Management reviewed November 25, 2024 noted that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property are reported immediately, but no later than 2-hours after the allegation is made. The policy also noted that all alleged violations are thoroughly investigated to prevent further abuse, neglect, exploitation or mistreatment. Review of the facility policy titled Abuse - Identification of Types reviewed May 6, 2025 stated that the facility staff should report any suspected abuse, neglect, or exploitation to the Executive Director or Director of Nursing.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records, review of facility documentation, review of the State Agency (SA) database, staff interviews, and review of policy and procedure the facility failed to ensure an allegation of exploitation (resident #46) was fully investigated. The deficient practice could result in allegations of abuse to include exploitation not being investigated and abuse/exploitation occurring in the facility. Findings include: Resident #46 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of fatty liver, hypertension, and protein-calorie malnutrition. A report submitted from another state agency was received by the State Agency (SA) on June 19, 2025 regarding an allegation of exploitation pertaining to resident #46. Review of the SA database revealed that the facility failed to submit a self-report regarding the allegation of exploitation. Further review of the SA database indicated that the facility failed to submit a thorough investigation regarding the allegation of exploitation. A written request for a copy of the incident report and the facility investigation pertaining to resident #46 was submitted to the facility on September 7, 2025 at 1:40 p.m. An email response was received from the Executive Director (ED/staff #411) on September 7, 2025 at 2:07 which stated that there are no incident or investigation found. An interview with a Licensed Practical Nurse (LPN/staff #24) was conducted on September 9, 2025 at 4:18 a.m. Staff #24 stated that it is important to investigate allegations of abuse to ensure the issue does not further escalate, ensure that the issue is not ignored, and have proof of what happened to document facts. The impact of not investigating allegations is that it can impact the resident (victim) poorly leading to depression and feeling like they are not seen/heard as human beings. Staff #24 is unfamiliar with the exploitation issue concerning resident #46. During an interview with a Certified Nursing Assistant (CNA/staff #101) conducted on September 9 2025 at 5:04 a.m., staff #101 stated that allegations of abuse/exploitation have to be investigated because residents are human beings and they have rights and those rights should not be violated. According to the CNA, the impact of not investigating allegations of abuse/exploitation is that the residents can end up depressed, the resident will be talking about the issue and each time there is a caregiver there can be hostility. An interview with the Social Services Assistant (SS Asst/staff #32) and the Social Services Director (SS Dir/staff #93) was conducted on September 9, 2025 at 10:02 a.m. Staff #93 noted that they found out about the exploitation due to non-payment of cost share. The SS Dir said that resident friend #666 visited resident #46 and there was an allegation of financial. exploitation. According to staff #93, the other state agency investigated the allegation of financial exploitation. During the course of the investigation, resident friend #666 was restricted from vising resident #46 per the previous administrator. An interview with the Assistant Director of Nursing (ADON/staff #90) was conducted on September 9, 2025 at 11:04 a.m. Staff #90 stated that his expectation is that any allegation of abuse is reported immediately to ensure that residents are protected and it can be investigated. According to the ADON he remembered that there was a concern that resident #46 was being exploited by resident friend #666 but there were no specific details. Staff #90 stated that exploitation is considered abuse and that all allegations of abuse is investigated by the facility. He noted that the allegation should have been investigated in collaboration with the other state agency. The facility policy titled Area of Focus: Incident and Reportable Event Management reviewed November 25, 2024 noted that all alleged violations are thoroughly investigated to prevent further abuse, neglect, exploitation or mistreatment.