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	12/08/2025

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 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. (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 0600 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 reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to protect the resident's (#100) rights to be free from abuse by another resident (#200). This deficient practice could result in further incidents of resident to resident abuse. Findings include: -Resident #100 (Perpetrator) was admitted to the facility on [DATE], with diagnosis that include Dementia, insomnia, anxiety, and malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated the resident had severe cognitive impairment. A review of resident's #100 care-plan revealed the resident has impaired cognitive ability related to dementia, and needs simple 1 to 2 step instructions. -Resident #200 (Victim) was admitted to the facility on [DATE], with diagnoses that include Spinal stenosis, diabetes mellitus type 2, weakness, anxiety, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06 which indicated the resident had significant cognitive impairment. A review of progress notes for resident #100 dated November 28, 2025 at 9:11 p.m. revealed resident #200 was traveling on the same side of the hall moving towards the direction of Resident #100. Resident #200 was heard saying don't you hit me. As the writer got up to separate the residents, Resident #100 was visualized reaching up with his right hand and punched resident #200 in the face twice. The note further revealed that other staff members arrived to assist, resident #100 was placed on a 1:1 with a staff member, and that the administrator, doctor, and law enforcement were notified. The note concluded that resident #100 was sent to the local hospital for further evaluation. A review of provider progress notes for resident #200 dated November 28, 2025 at 9:54 p.m. revealed resident #200 was being seen for a physician acute visit because resident #200 was examined after she was punched in the face by resident #100. The note continued that there was no major damage except light bruising, and some increased pain to her right shoulder. The note concluded that the provider increased the resident's prednisone back to 5 milligrams (mg) daily for pain. A review of Social services notes for resident #100 dated November 29, 2025 at 10:03 a.m. revealed the social services director had spoken to the house supervisor at the emergency room where resident #100 was taken, and that the facility would be unable to take resident #100 back and that they are looking for placement. An interview was conducted with a Certified Nursing Assistant (CNA/staff #5) on December 5, 2025 at 10:54 a.m. The CNA stated that normally resident #100 is usually gentle, but sometimes he would get agitated and they would just redirect him. The CNA stated he didn't witness the altercation between resident's #100 and #200 but he heard about it, and that it was an altercation. The CNA also stated it was the first time he knew of that resident #100 got physical with another resident. The CNA concluded that there are several types of abuse, including physical, verbal, neglect, and that abuse is doing something others wouldn't want them to do. An interview was conducted with a Licensed Practical Nurse (LPN/staff #10) on December 8, 2025 at 2:00 p.m. The LPN stated that resident #100 does have episodes of being unpredictable, and said he was in the facility previously and some days was very cooperative, and other days was cussing and swinging at staff. The LPN stated he doesn't remember if any of those episodes happened with other residents, but that it wasn't uncommon for resident #100 to swing at staff. The LPN further stated that the provider luckily was in the building at the time of the incident and saw resident #200 at bedside. The LPN continued that resident #200 had a busted lip after the incident, as well as some redness, but no other injuries. An interview with resident #200 was conducted on December 8, 2025 at 2:13 p.m. Resident #200 stated that she sure did get hit, and pointed to the right side of her mouth. Resident #200 further stated that she saw resident #100 coming down the hall, and told him not to come down this way. Resident #200 stated that resident #100 said I go where I damn well please and that she told him I'm not trying to make you angry and then resident #100 got real close to her, and moved towards her again. Resident #200 stated that she told him to go home and he replied no godammit I go where I please, grabbed resident #200 by the hand, and stated I'm gonna stop you and then hit her in the face, twice. Resident #200 continued that it busted her lip and bled for a bit inside her mouth, and that she had trouble eating because of it. Resident #200 further stated that she does feel safe in the facility, and that staff responded to the incident very fast. Resident #200 concluded that yes, it was obvious abuse. An interview was conducted with the Director of Nursing (RN/staff #50) was conducted on December 8, 2025 at 2:24 p.m. The DON stated that she was notified about a resident to resident altercation. She stated that she was told resident #100 had