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 02/02/2026
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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, staff interviews, and policy review, the facility failed to protect the resident's (#1) rights to be free from misappropriation from staff. This deficient practice could result in further incidents of staff to resident financial abuse. Findings include: -Resident #1 was admitted to the facility on [DATE], with diagnoses that include congestive heart failure, atrial fibrillation, ventricular tachycardia, thyrotoxicosis, and pulmonary embolism. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had no cognitive impairment. A review of the State Agency (SA) complaint system revealed that on January 8, 2026 at 5:22 p.m. an incident was reported by the facility that a local police department officer arrived to the facility at 3:30 p.m. and informed the receptionist that he needed to speak with the Director of Nursing. The Executive Director and Assistant Director of Nursing spoke with officer in the Executive Director's office and the officer expressed concern about a resident who recently discharged , identified as Resident #1. Resident #1 had reported charges to her card on December 12th, 14th and 15th. The officer explained they have video footage of a woman wearing scrubs and asked if they could identify this individual. After evaluation, they identified the picture to look like a CNA employed by the facility, Staff #20. The facility provided officer with Staff #20's date of birth and work schedule. The facility also notified another local facility as she is an employee of theirs as well. The officer, Director of Nursing, Assistant Director of Nursing had spoken about next steps. The Director of Nursing and Executive Director attempted to call Staff #20 with no answer. They agreed to return to facility at 10:00 p.m. when employees next shift is to terminate and collaborate with local law enforcement on upcoming arrest and investigation. As stated by the officer, the individual will be arrested on class 1 misdemeanor charge on January 8, 2026. Resident #1 was discharged from the facility on December 30, 2025.An interview with a Certified Nursing Assistant (CNA/staff #30) was conducted on February 2, 2026 at 4:39 p.m. Staff #30 stated she was aware of the incident of the stolen card, and that it was used at Walmart. Staff #30 stated that it was staff #20 who stole it and that she was taken off the schedule following the incident. Staff #30 further stated she was shocked to hear about the allegation and that it's never ok to steal from a resident. Staff #30 stated that absolutely she would consider it abuse, it's financial abuse. Staff #30 concluded that this was the only incident of this type that has happened that she was aware of. An interview with a Licensed Practical Nurse (LPN/staff #40) was conducted on February 2, 2026 at 4:58 p.m. Staff #40 stated they recently had training related to money and credit cards from residents over the recent incident. Staff #40 stated they heard an employee took a resident's credit card and used it, but that they did have recent training on it and that it is never ok to do that. Staff #40 stated that abuse can be all kinds of things, physical, sexual, verbal, and financial. Staff #40 stated that yes stealing a credit card would be financial abuse, and that the abuse (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

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	02/02/2026

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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordinator is the executive director Staff #50. An interview was conducted with the Executive Director (ED/staff #50) on February 3, 2026. Staff #50 stated that after resident #1 had discharged from the facility, she received a credit card statement in the mail and had $900 worth of charges on it for toys, whiskey, and anime all from a local department store. Staff #50 stated that the charges were in three separate trips over 2 days. Staff #50 stated that within hours the police had traced the receipt to their employee identified as staff #20, and had showed up to the facility to arrest her on potentially felony charges. Staff #50 stated she made 2 attempts to call staff #20 and couldn't get ahold of her. Staff #50 stated that the police met her at the facility at 10:00 p.m. that same day and had a meeting with staff #20, and with the police present and terminated staff #20's employment over the incident. Staff #50 stated that she spoke to the resident and that the credit card company had reimbursed the lost funds. Staff #50 concluded that of course this isn't the standard of their facility, and they substantiated the complaint in their report to the SA. A review of facility policy titled ‘Abuse - Identification of types reviewed May 6, 2025 revealed it is the policy of the facility to identify abuse, neglect, and exploitation of residents and misappropriation of resident property. This includes but is not limited to identifying and understanding the different types of abuse and possible indicators.