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	06/25/2026

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

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, resident, family, and staff interviews, and facility's policy review, the facility failed to protect the rights of one resident (Resident #10) to be free from abuse by another resident (#25). This deficient practice could place residents at risk for resident-to-resident abuse and potential physical harm.Findings include: -Resident #25 (Perpetrator) was admitted to the facility on [DATE], with diagnoses that include pulmonary embolism, acute respiratory failure, heart failure, and hypertension. The quarterly 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. The care-plan revealed the resident used antidepressant medication related to depression, with a goal of being free from adverse reactions and a noted goal to observe and report adverse reactions, and psyche follow up as indicated. -Resident #10 (Victim) was admitted to the facility on [DATE], with diagnoses that include heart failure, atrial fibrillation, aneurysms, insomnia, depression, and hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident had no cognitive impairment. The progress note dated June 6, 2026 at 2:14 p.m. revealed that during the morning medication pass, the writer heard resident #25 yelling and cussing toward a Certified Nursing Assistant (CNA) while threatening to kill his roommate (resident #10) because Resident #10's TV was too loud. The CNA connected headphones to Resident #10's TV and returned to work. The note further revealed that at 11:00 a.m., Resident #25 was again at the nursing station threatening to kill a CNA. Resident #25 then returned to his room and continued yelling. A housekeeper yelled for help to the nurse and the CNA. Upon entering the room, the nurse observed Resident #25 holding a detached wheelchair leg in his hand trying to go after resident #10. The CNA attempted to pull back resident #25's wheelchair and resident #25 slipped out of his chair. The note further documented that resident #10 pushed the wheelchair leg away from him and it hit resident #25 in the head, leading to a wound to his head that was bleeding, and a skin tear on his forearm from the fall. A review of skin assessments for resident #25 dated June 6, 2026 2:14 p.m. revealed resident #25 had a laceration to the head, evaluated by emergency services, and noted that resident #25 tried to hit another resident with the leg of his wheelchair, and upon trying to strike resident #10, resident #10 pushed the leg back striking resident #25 in the head. An interview with a Licensed Practical Nurse (LPN/ Staff #100) was conducted on June 25, 2026 at 1:39 p.m. Staff #100 stated that on the day of the incident resident #25 was stating he was going to kill his roommate over his TV volume. Staff #100 stated that staff fixed resident #10's Bluetooth for his TV to fix the issue but that 2 hours later resident #25 was found in his room attempted to strike resident #10 with a wheelchair leg. Staff #100 stated that a CNA attempted to remove resident #25 by pulling on his wheelchair, which resulted in resident #25 falling from the wheelchair while resident #10 simultaneously pushed the wheelchair leg away leading to it hitting resident #25 in the head. Staff #100 stated that she didn't think resident #10 had any injuries but that resident #25 had a skin tear on his leg, and a laceration on the top of his head. Staff #100 stated that police and emergency services were called and eventually resident #25 (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	was taken to the local hospital by the crisis team. Staff #100 stated the incident constituted resident-to-resident abuse and described resident #25 as very aggressive. An interview was attempted with resident #10 on June 26, 2026 at 8:45 a.m.; however, the resident was unable to provide reliable information regarding the incident. An interview was conducted with the Director of Nursing (RN/staff #50) on June 26, 2026 at 9:33 a.m. The DON stated that resident #10 is a poor historian, and has transient confusion. She further stated that resident #10 had no injuries, and resident #25 had a wound to his head. She further stated that resident #25 had psyche issues, was suicidal, and was receiving psychiatric services through a community mental health provider. The DON stated that there were no behavioral interventions documented in the care plan. She stated that the lack of care plan documentation was an oversight, however that interventions were in place and verified the resident had been seen by psyche services. The DON stated that the incident as she was told stemmed from resident #25 attempting to hit resident #10 with a wheelchair foot rest. The DON stated that she told staff to stay between the two residents until emergency services arrived and that after the incident resident #25 was moved to a new room before being taken by the crisis team to the hospital. The DON concluded that it was unfortunate the event happened and that resident #25 did not return to the facility. A review of facility policy titled ?Abuse - Prevention reviewed April 1, 2026 revealed it is the policy of the facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.