STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035140	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Tucson	6211 North LA Cholla Boulevard Tucson, AZ 85741

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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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
	035140	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Tucson	6211 North LA Cholla Boulevard Tucson, AZ 85741

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** BBased on clinical record review, interviews, the State Agency's (SA) complaint portal, and review of the facility's policies and procedures, the facility failed to ensure 4 out of 4 residents' (#47, #48, #52, and #53) medications were not misappropriated by nursing staff. The deficient practice resulted in the facility not keeping an accurate record of controlled substances. Findings include:Related to Resident #47-Resident #47 was admitted to the facility on [DATE] with diagnoses that included displaced intertrochanteric fracture of the right femur, generalized muscle weakness, stage 3 kidney disease and cognitive communication deficit. Review of the admission Minimum Data Set (MDS), dated [DATE], revealed Resident #47 had a Brief Interview for Mental Status (BIMS) and scored a 12 which indicated he had moderate cognitive impairment. The same MDS also indicated the resident was taking opioids as part of his medication regimen.The care plan, revised on May 24, 2024, revealed Resident #47 was on a PRN (Pro Re Nata or as needed) pain medication therapy related to multiple fractures, osteosarcoma and chondrosarcoma. Interventions included administering analgesic medications as ordered by the physician and to observe and monitor for possible side effects.A physician's order, dated April 23, 2024, indicated Resident #47 was to take Fentanyl patch 72-hour 75 MCG (micrograms)/HR (hour). Instructions stated to apply 1 patch, transdermally, every 72 hours for chronic pain and remove per schedule. The clinical record indicated this order was discontinued on April 29, 2024 due to a dosage increase.A new physician's order, dated April 29, 2024, indicated Resident #47 was to take Fentanyl patch 72-hour 100 MCG/hour. Instructions stated to apply 1 patch, transdermally, every 72 hours for chronic pain and remove per schedule.An entry, on Resident #47's Progress Note, dated May 4, 2024 at 5:58 P.M., was created by Registered Nurse (RN/Staff #61). The note indicated that Fentanyl patch was applied, changed and noted on the MAR.A second Progress Note entry was dated May 5, 2024 at 9:58 P.M. and was created by Staff #120. The entry noted that Fentanyl patch was applied and changed and noted on the MAR.An entry, on Resident #47's Progress Note, dated May 6, 2024 stated that the Nurse Practitioner (NP) and the resident's wife were notified about the missing Fentanyl patch, and the investigation is ongoing per DON (Director of Nursing). The entry was created by RN/Staff #51.Review of the May 2024 MAR revealed Staff #120 documented on May 4 at 7:28 AM that she had removed the Fentanyl Patch 100 mcg and at 7:29 A.M. she had applied a new patch. There was no documentation that reflected staff #61 had removed or applied the Fentanyl 100 mcg patch on May 4, 2024 as indicated on the Progress Note.Review of a complaint submitted to the SA complaint portal on May 10, 2024 at 8:08 A.M. indicated there was a possible drug diversion of Resident #47's Fentanyl by Staff #120. The facility's 5-day investigation included a controlled substance record for Fentanyl 75 mcg patch. The same record had an entry, dated May 4, recorded by Staff #120. The entry indicated at 7:00 A.M. a patch was taken and there was 1 patch remaining. There was a note written stating wrong pt (patient). The entry was signed by Staff #120 and the 2nd signature was illegible. The same 5-day investigation report indicated the 2nd signature was not able to be identified. The investigation report also included a Controlled Substance Record sheet for another resident who was in the facility at the time of this alleged incident. The record indicated the resident had an order for Fentanyl 75 mcg patch. However, the same record did not have documentation that the medication patch was given to the resident on May 4, 2024 or May 5, 2024.An interview was conducted on August 14, 2025 at 11:16 A.M. with Registered Nurse (RN/Staff #51), telephonically. Staff #51 shared that he had noticed a patch of Fentanyl 75 mcg missing and had reported it to his interim supervisor.An interview was conducted on August 14, 2025 at 12:00 P.M. with LPN/Staff #108. Staff #108 shared that when a resident is discharged and their narcotic medications are left at the facility, they continue the narcotic count and it is documented on the controlled substance count sheet. He continued to explain that the process is continued until the medication is destroyed by the ADON and the DON. He shared that he had never destroyed medications but he understood the process of destroying medications was needing to be done by two nurses.An interview was conducted on August 15, 2025 with LPN/Staff #97 at 11:17 A.M. Staff #97 explained the process for managing controlled substances as continuing to keep the medication in the lockbox until the DON and the ADON collect it. They then take it somewhere to destroy the medication. She shared that they still continue to include the medication in their narcotic count every shift until it is removed to keep track of how many medications they have on hand. She added that the risk of not doing so would be the medication being given to the wrong patient and the facility not keeping an accurate count of how many

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035140	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Tucson	6211 North LA Cholla Boulevard Tucson, AZ 85741

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035140	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Tucson	6211 North LA Cholla Boulevard Tucson, AZ 85741

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 0684 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 review, interviews, the State Agency's (SA) complaint portal, and review of the facility's policy and procedures, the facility failed to ensure a resident (#40) received medications according to physician's orders. The deficient practice could result in resident experiencing unnecessary pain.Findings include: Resident #40 was admitted to the facility on [DATE] with diagnoses that included Dementia, fusion of the spine in the cervical region, and a fracture of the humerus in the right arm. The care plan, initiated on August 9, 2023, indicated Resident #40 was on pain medication therapy related to chronic pain syndrome. Interventions included administering analgesic medications as ordered by the physician and to observe for side effects and effectiveness of the medications.A physician's order, dated September 18, 2023, revealed an order for Dilaudid (Hydro-morphine HCl) Oral Tablet 2 MG (milligrams). The order indicated that .5 mg tablet was to be given every 4 hours as needed for pain 4-10.Review of the Narcotic Count Sheet for Hydro-morphine HCL 2 mg tablet starting October 9, 2023. The documentation revealed that Licensed Practical Nurse (LPN/Staff #120) logged out doses on the following days and times:- October 18 at 7:00 P.M. and 11:00 P.M.- October 19 at 7:00 P.M., and 11:00 P.M.- October 25 at 7:00 P.M. and 11:00 P.M. - October 26 at 3:00 A.M., 7:00 A.M., and 7:00 P.M.- October 27 at 11:00 P.M., 3:00 A.M., and 7:00 A.M.Review of the October 2023 Medication Administration Record (MAR), provided by the facility, indicated that Dilaudid Oral Tablet 2 MG was not administered on October 18, 19, 24, and 25 by Staff #120.Review of the staff schedule reveals that the night shift is from 6:00 P.M. to 6:00 A.M.Review of the facility's 5-day report submitted to the SA regarding Resident #40 revealed that Resident #40 was complaining of pain on October 27, 2023 at 10:15 A.M., however the nurse working that shift was unable to administer pain medication due to the narcotic count sheet indicating the medication was last given at 7:00 A.M. The same report revealed that the medication cart keys was handed to the day shift nurse at 6:40 A.M. which was prior to the 7:00 A.M. medication log out time indicated on the Narcotic Count Sheet. The same 5-day report included a statement from the day shift nurse, LPN/Staff #121. The statement revealed that Resident #40 was medicated with Dilaudid at 11:16 A.M.A telephone interview was attempted on August 15, 2025 at 9:41 A.M. with Staff #121, however the phone number was not in service.An interview was conducted with Staff #67 on August 15, 2025 at 12:31 P.M. Staff #67 shared that when a resident is discharged without their narcotic medications, the medication gets destroyed by a nurse manager. She indicated that the documentation of the destruction is documented via the pharmacy website when her and the ADON destroys it. When asked what happened with Resident #40's Dilaudid medication, Staff #67 explained that Staff #120 signed the medication out on the Controlled Substance Count sheet but did not document the administration on the MAR. She said it was reasonable that Staff #120 did administer the medication but did not document it or it was signed off on the sheet and not given to the resident and possibly stolen. When asked if it was reasonable for the documentation to take place in one area and not the other area 8 times by the same staff in a short time frame, Staff #67 indicated that it was not reasonable and there was a possibility that the medication was diverted. She shared that possible diversion would be a risk to residents because they would not be getting their pain medications and they would be in pain. She also shared that documenting medication administration on the Narcotic Count Sheet and not the MAR did not meet her expectations.Review of the policy titled, Administration of Medications, indicates the policy was last reviewed on September 16, 2024. The policy states that The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.Review of a second policy titled, Abuse, indicates the policy was last reviewed on May 6, 2025. The policy states that Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent. It also provides examples of misappropriation which included Missing prescription medications or diversion of a resident's medication(s), including but not limited to, controlled substances for staff use or personal gain.