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	01/05/2026

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 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 interviews, review of records, and review of facility policy and procedure, the facility failed to protect the rights of one of three sampled residents (#119) to be free from abuse by another resident (#103). The deficient practice could lead to ongoing abuse, leading to harm to other residents.-Findings include:Regarding Resident #119Resident #119 (alleged victim) was admitted to the facility on [DATE], with diagnoses including displaced fracture of the surgical neck of the right humerus, cognitive communication deficit, unsteadiness on feet, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, age-related cognitive, mood affective disorder, and insomnia.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS further revealed that Resident #119 had exhibited no verbal or physical behavioral symptoms directed towards others during the assessment period.Review of Resident #119's care plan, which was initiated on October 11, 2025, revealed a risk for impaired cognitive ability and impaired thought processes regarding the diagnosis of dementia. Interventions included: cueing, orienting, and supervising Resident #119, as needed.Resident #103 (alleged perpetrator) was admitted to the facility on [DATE], with diagnoses including Parkinson's disease without dyskinesia, unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, restlessness and agitation, anxiety disorder, major depressive disorder, and insomnia.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS further revealed that Resident #103 had exhibited no verbal or physical behavioral symptoms directed towards others during the assessment period.Review of Resident #103's care plan, which was initiated on November 14, 2023, revealed a risk for change in behavior due to the medical condition dementia with behaviors. Interventions included consulting with Resident #103 on references regarding customary routine. Another care plan risk initiated on May 13, 2025, revealed a risk for Resident #103 to be physically aggressive during the activities of daily living (ADL) care and showers. Interventions included monitoring for behaviors while in the dining area and Resident #103 touching/striking other residents or staff. -Regarding the December 12, 2025, incidentOn December 12, 2025, an event progress note was entered into the clinical record for Resident #119. It stated that Resident #119 was sitting in the hall surrounded by other residents. Resident #119 was heard yelling at another resident. Resident #103 was screaming as well and hitting Resident #119 with a stuffed animal across the chest. Resident #103 then began kicking resident #119 back. Residents were immediately separated and placed on 15-minute checks. The medical director was at the facility and was made aware. Skin checks were performed, and no redness was noted.Review of a skin assessment for Resident #119 on December 12, 2025, revealed that Resident #119's skin was intact (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
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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	with no redness or bruising. On December 12, 2025, an event progress note was entered into the clinical record for Resident #103. It stated that Resident #103 was sitting in the hallway surrounded by other residents. Resident #103 was heard yelling at another resident as well as hitting Resident #119 with a stuffed animal across the chest. Resident #119 then began kicking Resident #103 in the leg. Residents were immediately separated and placed on 15-minute checks. The medical director was at the facility and was made aware. Skin checks were performed, and no redness was noted.Review of a skin assessment for Resident #103 on December 12, 2025, revealed that Resident #103's skin was intact with no redness or bruising.Review of the facility's undated 5-day investigation report regarding the altercation that occurred on December 12, 2025, revealed that the facility verified the allegation the by evidence collected. Further review indicated that both residents were unable to recall the incident and residents #119 and #103 were referred to the psych provider. An interview was conducted with Assistant Director of Nursing (ADON/Staff #54) on January 5, 2026, at 11:27 a.m. Staff #54 stated that on December 12, 2025, at approximately 3:30 p.m. she heard screaming outside of her office. Staff #54 then witnessed Resident #103 hitting Resident #119 across the chest with a stuffed animal and Resident #119 kick Resident #103 in the leg. After separating the residents, Staff #54 then witnessed the residents crying. She assessed both residents for physical injuries and no injuries were noted. Staff #54 stated she could not recall any other resident to resident altercations involving Resident #119, but said Resident #103 did have at least one other altercation with another resident. Staff #54 stated that she was the only staff member to witness the incident and she would consider this incident to be abuse. An interview was conducted with the Facility Administrator and Abuse Coordinator (Staff # 131) on January 5, 2026, at 12:55 p.m. Staff #131 stated that physical abuse can occur and can be substantiated without physical injuries. Review of a facility policy titled, Abuse-Prevention, issued October 4, 2022, and reviewed May 6, 2025, revealed that the facility's procedure includes identification, assessment, and a care plan for appropriate interventions and monitoring of residents with needs and behaviors that might lead to conflict. These include verbally and physically aggressive behaviors.