

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Tucson		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure 1 of 3 sampled residents (Resident #1) was free from verbal abuse by a staff member. The deficient practice could result in other residents being abused. Findings Include:-Regarding Resident #1:Resident # 1 (alleged victim) was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus with foot ulcers, absence of left foot, morbid obesity, and mood disorder. A comprehensive care plan initiated on August 25, 2025 revealed that the resident had an activity of daily living (ADL) self care performance deficit due to activity intolerance. The care plan further revealed interventions that included toilet use requiring maximum assistance and requiring 2-person dependent assist with transfers. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident is cognitively intact. The MDS also revealed that the resident required substantial assistance for toilet transfers. An Event Note dated March 27, 2026, documented that Resident # 1 was wheeling herself in her wheelchair in the hallway to the nurses' station to request assistance. The note indicated that Resident # 1 was requested a brief change. At that time, a Certified Nursing Assistant (CNA/Staff #169) seated at the nurses' station heard the resident, turned around and made an inappropriate comment. The note further documented that the resident began crying following the interaction.-Regarding Staff #169:Review of Staff #169's (alleged perpetrator) personal file revealed that she was employed as a CNA with a hire date of February 27, 2025.An Education Acknowledgement Form dated December 17, 2025 revealed that Staff #169 was trained on the use of Professional language. The acknowledgement form further revealed the summary of the training included that Staff # 169 should use professional language when reporting to co-workers and residents. Using profanity is prohibited at work. Review of the Acknowledgment for revealed that Staff #169 signed the form on December 17, 2025. Further review of Staff #169's personnel record revealed a certificate of completion of Annual General Requirements Curriculum on March 11, 2026. The certificate revealed that the curriculum topics included Abuse, Neglect, and Exploitation: Mandatory Reporting, Resident Rights, Respect in the Workplace, and The Elder Justice Act, Prevention of Abuse in Persons with Dementia: Mental Health & Psychosocial Needs of Residents; and Person-Centered Care. A Suspension Pending Investigation Form dated March 27, 2026 revealed that at approximately 6:45 a.m. it was reported that Resident # 1 was asking Staff # 169 for help. It was reported that Staff # 169 cursed and told Resident # 1 it was her fucking fault while turning away from Resident and going downstairs. The Suspension Form also revealed that Staff # 169 was placed on suspension pending investigation.The Suspension Pending Investigation Form further revealed a section to be completed after the investigation which was signed on March 29, 2026 by Director of Nursing (DON/Staff # 43). The section revealed that the facility unsubstantiated the allegation however Staff # 169 resigned via text. A Facility investigation report submitted April 1, 2026 revealed that Resident # 1 was interviewed and claimed she did not receive any patient care the morning of March 27, 2026 and had urinated over herself and put on her call light but Staff # 169 would not (continued on next page)</p>

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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Staff # 169 refused and according to the statement at one point Staff # 169 told Resident # 1 that it was resident's fucking fault. The statement revealed that Resident # 1 went back to her room crying and Staff # 118 went to comfort her. Staff # 118 report incident to his supervisor who instructed to call DON and Administrator. The Facility investigation report further revealed a written statement by Staff # 169 dated March 27, 2026 from Staff # 169. The statement revealed that Resident # 1 had turned on her call light at 4:00 am when Staff # 169 and another unnamed CNA was doing their last rounds and was not able to help at that time because no one was able to go with Staff # 169 and provide care to Resident # 1 due to the 2-person assist. The statement revealed that after 5:00 a.m. Resident # 1 came out of her room angry and said she should not have to wait so long. The statement revealed that Staff # 169 claimed she agreed with Resident #1 stood and went downstairs to get another unnamed CNA to help assist Resident #1. In the statement Staff # 169 revealed she may have said the term fuck when she went downstairs but denied that it was directed at Resident # 1. An attempted interview with Resident #1 on April 23, 2026 at 8:15 am revealed that Resident # 1 had been sent to the emergency room the night before due to arm pain. Phone call to Resident # 1 was attempted at 10:06 a.m. but was unable to connect with Resident # 1. An interview was conducted with Staff # 38 on April 23, 2026 at 9:18 a.m. who stated that she saw Resident # 1 in the dining room and Resident # 1 told Staff # 38 that she had a rough morning because she needed help and Staff # 169 was rude. Staff # 38 stated Resident # 1 told her that Staff # 169 was rude to her and blamed her for not getting cares because of the cares in pairs. Staff # 38 revealed that she believed Resident # 1's mood to be fine and resident did not seem distraught over it or crying at that point. An interview was conducted with Staff # 118 on April 23, 2026 at 9:22 a.m. who stated that he got to Resident # 1's floor around 5:15 a.m. because they had conducted a fire drill earlier and he was getting everyone to sign the maintenance book., Staff # 118 stated when he got to the floor there were a lot of call lights on including the call light to Resident # 1. Staff # 118 stated that he saw Staff # 169 sitting at the nurses station on her phone watching what he thought was a movie. Staff # 118 stated that Resident # 1 came out of her room and asked Staff # 169 asking for help getting her brief changed. Staff # 118 stated that Staff # 169 kept refusing because she was the only one on the floor at the time and did not have another person to help because she is cares in pairs. Staff # 118 stated Staff # 169 stood up and told Resident # 1 it's your own fucking fault. Staff # 188 stated that Resident # 1 began to cry and went back into her room while Staff # 169 sat back down at the nurses station and returned to watching her phone. Staff # 118 then said Staff # 169 stopped watching her phone stood up and said I'm already expecting a call from (DON) tonight but I don't give a shit. Staff # 118 stated that he went to Resident # 1's room to comfort her and reported the incident to his supervisor who instructed him to report do DON and Administrator. Staff #118 stated that he never witnessed Staff # 169 get a second person to help Resident # 1. The interview with Staff # 118 and the written statement from Staff # 118 documented on March 27, 2026 were consistent. An interview with CNA, Staff #24, on April 23, 2026 at 9:38 a.m. revealed that Resident # 1 was in cares in pairs because the resident accused staff of not helping her. Staff # 24 revealed that Resident # 1 likes to press her call light a lot and it can be difficult due to the cares in pairs to get her help immediately and Resident # 1 is known to want care immediately at times. Staff # 24 revealed if you communicate with her what is going on including the delay then she will back off on the requesting (continued on next page)</p>		

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