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	07/17/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on record review and staff interviews, the facility failed to ensure that two residents (#222 and #223) and/or the resident's representative received an accurate and complete Advanced Beneficiary Notice (ABN) when Medicare services terminated. The deficient practice could result in residents not knowing of their potential liability for payment. Findings include: Resident #222 was admitted on [DATE] with diagnosis including urinary tract infection, difficulty walking, muscle weakness, arteritis, hypothyroidism, hyperlipidemia, repeated falls, neuromuscular dysfunction of the bladder, and protein-calorie malnutrition. A review of the admission MDS (minimum data set) dated January 7, 2024 revealed a BIMS (brief interview of mental status) score of 00, suggesting severe cognitive impairment. A review of the advanced beneficiary notification for resident #222 revealed the estimated cost for ongoing care effective on February 2, 2024 would be $345.00 a day. The form further revealed that both option 1 and option 3 had been selected in the area that indicated to check one box only. The directions on the form stated to select only one option. Option 1 noted that the care as listed above, outlining the $345.00 a day fee, was wanted, and option 3 noted that the resident does not want the care as listed above. Option 1 and option 3 are in conflict with one another. ______________________________ Resident #223 was admitted on [DATE] with diagnosis including knee pain, patella fracture, depression, glaucoma, irregular heartbeat, obesity, osteoarthritis, breast cancer and spinal stenosis. A review of the 5-day MDS (minimum data set) dated November 29, 2023 revealed a BIMS (brief interview of mental status) score of 15, suggesting that the resident was cognitively intact. A review of the advanced beneficiary form for resident #223 revealed that the estimated cost, to the resident, beginning December 05, 2024 would be $345.00 a day. The 'options-section' of the form denoting that only one box should be checked revealed that no boxes were checked, leaving ambiguity as to whether resident #223 was opting to continue or not continue with services past December 05, 2023. (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: 035140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
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)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	______________________________ An interview was conducted on July 16, 2024 at 3:13 P.M. with staff #112 (Social Services Director). Staff #112 stated that she believed the advanced beneficiary notification (ABN) was always required for each resident when they are running out of Medicare days of service. Staff #112 stated that only one box should be checked for those sections explicitly stating check one box and that this section is required to be completed. Staff #112 reviewed the ABN for resident #223 and stated that a check-box should have been selected, but had not. Staff #112 reviewed the ABN for resident #222 and stated that only one box should have been checked not 2, as observed on the form. Staff #112 stated that the risk would include, that if the form was incorrectly completed, it would make the form invalid. Staff #112 stated that these forms were completed inaccurately and that she takes full responsibility for the errors. Staff #112 stated that going forward one person will be completing the form, another person will audit it for accuracy and it will be documented in point click care (PCC). An interview was conducted on July 16, 2024 at 3:27 P.M. with staff #110 (administrator). Staff #110 stated that her expectation is that the ABN is given timely and accurately. She stated that the ABN is completed by social services. Staff #110 reviewed the ABN documentation for resident #223 and resident #222 and stated that these should have been completed accurately, but the options section of the ABN was not accurately completed for either resident. Staff #110 stated that the risk could include reimbursement being impacted as well as an impact on resident rights. A review of the policy entitled Resident Rights with a review date of September 25, 2023 revealed that the resident has the right to request, refuse and or discontinue treatment.

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on observation, staff interviews, facility documentation, policy and procedures, the facility failed to ensure adequate and comfortable temperature levels was provided to meet the needs of 14 residents (#4, #5, #8, #11, #20, #25, #34, #35, #41, #42, #43, #48, #56, and #167). The deficient practice could result in the resident's room not having a homelike and comfortable environment. The facility census was 58 and the sample was 14. Findings include: On the morning of July 15, 2024, between the hours of 6:45 a.m. to 7:00 a.m., surveyors experienced a notable difference in temperature perceived and felt when entering the facility. The temperature felt uncomfortably warm. During an interview with the Assistant Maintenance Technician (staff #33) conducted on July 15, 2024 at approximately 6:45 a.m., staff #33 mentioned that the generator did not kick in properly during the power outage yesterday evening. This resulted in the cooling tower (chiller) not activating to cool down the temperature in the facility. Staff #33 stated that the chiller is in the process of kicking in but will take approximately 4 hours to cool down the facility. An observation of the residents' areas was conducted on July 15, 2024 starting at approximately 7:15 a.m. There was no evidence that rooms were being tested for ambient temperature by the staff. This was despite the residents' areas being noticeably and feeling warm/uncomfortable. Regarding Resident #4: -Resident #4 was admitted to the facility on [DATE] with diagnoses that included fracture of the lower end of the right femur, pain in right knee, chronic kidney disease, and osteoarthritis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating that the resident was cognitively intact. The assessment also revealed that the resident was dependent for transfers. The MDS indicated that the resident uses a walker as a mobility device. During an interview conducted with the resident on July 15, 2024 at 8:23 a.m., the resident stated that last night they had no power and that she was uncomfortable. An observation was conducted of the resident's room on July 15, 2024 at 8:23 a.m. There was a notable warm temperature in the room. Regarding Resident #5: -Resident #5 was admitted to the facility on [DATE] with diagnoses that included pressure ulcer of sacral region, osteoporosis, hypertension, and gastro-esophageal reflux disease. (continued on next page)

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 07/17/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has modified independence pertaining to decisions regarding tasks of daily life. The assessment also indicated that the resident required substantial assistance for chair to bed transfers, and sit to stand activities. The MDS also noted that the resident uses a wheelchair as a mobility device. During an interview conducted on June 15, 2024 at 8:19 a.m., the resident responded Si when asked if it was warm in their room. An observation was conducted of the resident's room on June 15, 2024 at 8:19 a.m. The temperature registered 80.7? Fahrenheit. The room felt noticeably warm. During a walk-through inspection conducted with the Maintenance Director (staff #32) conducted on July 15, 2024 at 9:30 a.m., the temperature was taken with a thermometer and registered 76.6 Fahrenheit. Regarding Resident #8: - Resident #8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, chronic obstructive pulmonary disease, angina pectoris, and peripheral vascular disease. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has modified independence when it came to decisions regarding tasks of daily life. The MDS also indicated that the resident is dependent on assistance with regards to most transfers. The MDS also noted that the resident uses a wheelchair for mobility. During an observation of the resident's room on July 15, 2024 at 8:17 a.m., the temperature taken with the thermometer registered 81.2? Fahrenheit. Physical inspection of the air conditioner (AC) thermostat located in the room revealed that the controls do not work regardless of the setting. The room felt uncomfortably warm. An interview with the resident was conducted on July 15, 2024 at 8:17 a.m. Resident #8 confirmed that it is hot in the room. During a walk-through inspection conducted with the Maintenance Director (staff #32) conducted on July 15, 2024 at 9:29 a.m., to check the temperature in the residents' area, resident #8's room temperature registered 81.1 degrees Fahrenheit. Regarding Resident #11: -Resident #11 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included paroxysmal atrial fibrillation, antherosclerotic heart disease, dementia, and paralytic syndrome. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. The MDS assessment also indicated that the resident is dependent on assistance for transfers. (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the resident's room was conducted on July 15, 2024 at 8:26 a.m. During the observation, the room felt hot. The temperature taken with a thermometer registered 81.1 Fahrenheit. During an interview with resident #11 conducted on July 15, 2024 at 8:26 a.m., the resident said that hell yeah, it's hot referring to his room. In a follow-up observation conducted on July 15, 2024 at 9:33 a.m., it was noted that the temperature in the room was finally comfortable. The temperature taken with the thermometer registered 76 Fahrenheit. Regarding Resident #20: -Resident #20 was initially admitted to the facility on [DATE] on readmitted on [DATE] with diagnoses that included quadriplegia, chronic obstructive pulmonary disease, heart failure, esophagitis, schizophrenia, and bipolar disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact. The assessment noted that the resident is dependent on assistance for transfers. The MDS also indicated that the resident utilizes a wheelchair as a mobility device. An observation conducted on July 15, 2024 at 8:12 a.m. revealed that the room was uncomfortably hot. The temperature taken with a thermometer registered 83.5 Fahrenheit. In an interview with resident #20 conducted on July 15, 2024 at 8:12 a.m., the resident stated that they did not have AC (air conditioner) in their room since Friday. The resident said that on Friday, July 12, the AC was fixed just before supper. However, it stopped working through the night Friday into Saturday. The resident noted that maintenance looked at it yesterday and it was still not working. During a walk-through inspection conducted with the Maintenance Director (staff #32) conducted on July 15, 2024 at 9:29 a.m., the room was still felt uncomfortably hot. The temperature was taken with a thermometer and it registered at 82.4 Fahrenheit. Regarding Resident #25: -Resident #25 was admitted to the facility on [DATE] with diagnoses that included anemia, heart failure, diabetes, and depression. Review of the Significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that he is cognitively intact. The assessment also indicated that the resident is dependent on assistance for all transfers. The MDS noted that the resident uses a wheelchair as a mobility device. (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A CNA (Certified Nursing Assistant/staff #9) was observed entering resident #35's room on July 15, 2024 at 8:35 a.m. Resident #35 was heard asking the CNA to turn on his air conditioner (AC). Staff #9 informed the resident that they did not think that the AC was working. The CNA told resident #35 that the thermostat was set at 74 Fahrenheit and stated that the AC had not been working but that they would report it to the Maintenance Director. Staff #9 noted that that AC was also not working in room [ROOM NUMBER] this morning and that it they reported it to the Maintenance Director when he was up on the second floor. An interview with a CNA (Certified Nursing Assistant/staff #9) was conducted on July 15, 2024 at approximately 8:38 a.m. Staff #9 said that the process is that they would document in a book at the nurse's station when things are not working. The CNA noted that they are going to document the issue right now. During an interview with resident #25 conducted on July 15, 2024 at approximately 8:40 a.m., resident #35 stated that he was hot last night and told a CNA last night. The resident was informed by that CNA that the air was not working and that there was nothing she could do about it. The resident said that they were told there was a fan. However, they did not see one. Resident #25 stated that they did not sleep well because they were hot. They said that they woke up at 3:00 a.m. and it was still hot. The resident noted that they were offered water through the night and cold cloth. An observation of the resident's room was conducted on July 15, 2024 at 8:55 a.m. The temperature was taken using a thermometer and registered 82.4 Fahrenheit. The wall-mounted thermostat was set at 74 Fahrenheit and the reading of the actual room temperature was displayed 84 Fahrenheit. Regarding Resident #34: -Resident #34 was admitted to the facility on [DATE] with diagnoses that included dementia, hypertension, and type 2 diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating that the resident is cognitively intact. The MDS also indicated that the resident utilizes a walker as a mobility device. An observation of the resident's room was conducted on July 15, 2024 at 8:24 a.m. During the observation, the room was noticeably hot. A look at the wall mounted thermostat located in the room revealed the temperature to be 84 Fahrenheit. A thermometer was used to take the room temperature and it registered 83. 0 Fahrenheit. A walk-through inspection was conducted with the Maintenance Director (staff #32) on July 15, 2024 at on July 15, 2024 at 9:33 a.m., the temperature was taken using a thermometer and it registered 74.3 Fahrenheit. Regarding Resident #35: -Resident #35 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included systolic heart failure, dysphagia, Takotsubo syndrome, dementia, and anxiety disorder. (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident makes independent decision regarding tasks of daily life. The assessment indicated that the resident requires substantial/maximum assistance for most transfers. The MDS also noted that the resident utilizes a wheelchair as a mobility device. An observation of the resident's room was conducted on July 15, 2024 at 8:20 a.m. The room was observed to have the AC on. However, it was only blowing room temperature air. The temperature was taken using a thermometer and it registered 81.8 Fahrenheit. An interview with resident #35 conducted on July 15, 2024 at 8:20 a.m., the resident stated that the is very warm. During a walk-through inspection conducted with the Maintenance Director (staff #32) conducted on July 15, 2024 at 9:31 a.m., the temperature was taken with a thermometer and it registered 79.5 Fahrenheit. Regarding Resident #41: -Resident #41 was admitted to the facility on [DATE] with diagnoses that included acute embolism, atherosclerotic heart disease, hypertension, depression, and obstructive and reflux uropathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact. The MDS also indicated that the resident is dependent on assistance for transfers. The assessment also noted that the resident uses a wheelchair as a mobility device. An observation of the resident's room was conducted on July 15, 2024 at 8:20 a.m. During the observation, it was noted that the AC was on but was only blowing room temperature air. The temperature was taken using a thermometer and it registered 81.8 Fahrenheit. During an interview with resident #41 conducted on July 15, 2024 at 8:20 a.m., the resident stated that it was warm in the room. A walk-through inspection was conducted with the Maintenance Director (staff #32) on July 15, 2024 at 9:31 a.m. During the inspection, the temperature was taken with a thermometer and it registered 79.5 Fahrenheit. Regarding Resident #42: -Resident #42 was admitted to the facility on [DATE] with diagnoses that included heart failure, hypertension, diabetes, paraplegia, and seizure disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact. The MDS indicated that the resident requires partial/moderate assistance for some transfers. (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the resident's room was conducted on July 15, 2024 at 8:11 a.m. During the observation the resident's room felt uncomfortably warm. The temperature was taken using a thermometer and the inner wall by the resident's restroom registered 87.1 Fahrenheit while the wall by the window registered 83.3 Fahrenheit. Regarding Resident #43: -Resident #43 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes, chronic kidney disease, anxiety disorder, depression, and gastro-esophageal reflux disease. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. The assessment indicated that the resident is dependent on assistance for all transfers. The MDS also noted that the resident uses a wheelchair as a mobility device. An observation of the resident's room was conducted on July 15, 2024 at 8:09 a.m. During the observation, the resident's room was noted to be pretty warm. The temperature was taken with a thermometer and it registered 82.6 Fahrenheit. An interview with resident #43 was conducted on July 15, 2024 at 8:19 a.m. Resident #43 stated that the during dinner last night, a storm hit town and a power outage ensued as they finished dinner. Due to the fire outage, the elevator was not functional, fire doors closed, and after awhile the emergency lights came on. However, the elevators remained non-functional. The resident noted that they were unable to get back to their room upstairs so they were instead placed in room downstairs until the power came back on. Resident #43 noted that the power came back on between 10:30 p.m. to midnight. The resident said that when they got upstairs, it was so hot and the doors were closed so it was really hot in their room. The resident noted stated that there was no air conditioning, no fan in the room and it was so uncomfortable due to the heat. When they woke up in the morning, it was really hot and uncomfortable. They noted that it was so hot in their room that even the CNA (Certified Nursing Assistant) was sweating and wiping herself with paper towels as she was helping them. The resident noted that they almost could not breathe because it was so hot. The resident explained that they came back downstairs to grab breakfast and to cool down. Resident #43 said that last night, what the staff did to assist with the heat was to give him cold water and just not put blankets on him. The resident explained that in their case, the room have to be kept at 73 Fahrenheit otherwise they are uncomfortable. Resident #43 noted that last night the heat is too bad and it was so bad that even with oxygen and the CPAP (continuous positive airway pressure) machine, they still could not breathe right. The resident mentioned that this was the longest that they had to go without AC. However, they mentioned that this happens every summer. Resident #43 noted that since the beginning of this summer, the air in the hallway has not worked and that was the reason why there was a fan on in the hallway even before the power outage. A walk-through inspection was conducted with the Maintenance Director (staff #32) on July 15, 2024 at 9:38 a.m. The temperature was taken with a thermometer and it registered 81.0 Fahrenheit. Regarding Resident #48: (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #48 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included seizures, narcolepsy without cataplexy, dysphagia, aphasia, depression, meningitis, diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has severely impaired cognitive skills for daily decision making. The MDS also indicated that the resident is dependent on assistance for all transfers. An observation of the resident's room was conducted on July 15, 2024 at 8:17 a.m. During the observation, it was noted that the AC (air conditioner) in the resident's room was not working. Physical inspection of the thermostat was unremarkable. However, the controls do not work regardless of the setting. In an interview with resident #48 conducted on July 15, 2024 at 8:17 a.m., the resident noted that the AC does not work. Resident #48 confirmed that it is hot in the room. A walk-through inspection was conducted with the Maintenance Director (staff #32) on July 15, 2024 at 9:29 a.m. During the inspection, the temperature was taken with a thermometer and registered 81.1 Fahrenheit. Regarding Resident #56: -Resident #56 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, epileptic seizures, gastric ulcer, bipolar disorder, and gastro-esophageal reflux disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating that the resident is cognitively intact. The MDS noted that the resident utilizes a wheelchair as a mobility device. An observation of the resident's room was conducted on July 15, 2024 at 8:24 a.m. The wall mounted thermostat displayed the room temperature at 84? Fahrenheit. The temperature was taken using a thermometer and registered 83.0 Fahrenheit. A walk-through inspection was conducted with the Maintenance Director (staff #32) on July 15, 2024 at 9:32 a.m. The temperature was taken using a thermometer and it registered 74.3 Fahrenheit. Regarding Resident #167: -Resident #167 was admitted to the facility on [DATE] with diagnoses that included pulmonary embolism, gastrointestinal hemorrhage, multiple sclerosis, polycystic ovarian syndrome, type 2 diabetes, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact. The MDS noted that the resident utilizes a walker as a mobility device. (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the resident's room was conducted on July 15, 2024 at 8:10 a.m. The temperature was taken with a thermometer and registered 79 Fahrenheit. During an interview with the resident conducted on July 15, 2024 at 8:10 a.m., the resident stated that they did not have a functioning air conditioning the first week that they were here. The resident said that they told the facility but they did not fix the issue until last week Monday or Tuesday. Resident #167 noted that there was a power outage last night and it was very hot and humid. The resident noted that the power did not come back on until 11:30 p.m. The resident said that they woke up from the noise and looked at their watch and that was how they knew when the power came back on. The resident noted that the nurse had checked on them and opened the window for them. A follow-up interview was conducted with a CNA (Certified Nursing Assistant/staff #9) on July 15, 2024 at 9:22 a.m. The CNA noted that they are supposed to move the resident when it is hot and the air is not working. On July 15. 2024 at 9:22 a.m., it was observed that the staff were transferring residents from the second floor to the first floor. An interview with the Maintenance Director (staff #32) was conducted on July 15, 2024 at 9:41 a.m. Staff #32 stated that they were notified at 6:15 p.m. of the power outage. They then called the Assistant Maintenance Technician (staff #33) and got ready to go out to the facility. Staff #32 noted that they arrived at the facility at approximately 6:45 p.m. They noted that the facility was dark, and the staff was panicking. They both started troubleshooting, checked the electrical room, and checked the breakers. It appeared that the main breaker for the building was popped, so they kicked it on. They turned the generator on manually at around 7:40-8:00 p.m. Staff #32 noted that it took about an hour to troubleshoot. They did not get the chillers working again since it took too much voltage. However, there was enough power for oxygen, air mattress, CPAP (Continuous Positive Airway). The staff #32 noted that downstairs it was 75 degrees and upstairs it was 78 degrees. The Maintenance Director noted that chiller temperatures have to be 80 and 90 always a 10-degree difference. When they got arrived in the facility in the morning, they did not know that the circular pumps went off. They had to go though each unit at 7:00 a.m. to reset all the AC (air conditioner) units. The Maintenance Director said that staff #33 had bypassed the circular pumps because they turned the alarm and did not share this with staff #32. Had the alarm been on, they would have known there was an issue with the circular pumps. (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with a Registered Nurse (RN/staff #69) was conducted on July 15, 2024 at 10:10 a.m. Staff #69 stated that the electricity went out last night around 6:15-6:20 p.m. The RN indicated that they checked and instructed staff that residents on O2 (oxygen) had to be put on the O2 tank. Staff #69 indicated that they are familiar with which residents are on O2. The RN stated that the first priority is to get the residents on O2 then checked each room to make sure that everyone was fine. They explained to residents that there was a storm and electricity is out and staff made sure that everyone had ice water. Staff #69 noted that by the time they notified maintenance, one of the nurses had already contacted the ED (Executive Director/staff #110) and the DON (Director of Nursing/#59). Maintenance arrive approximately 15-20 minutes later. The generator came on bout 15-20 minutes later. The RN noted that the O2 concentrators can be ran by the generator but no CPAP/BiPAP (Continuous Positive Airway/Bilevel Positive Airway Pressure) and they have to use the red plugs. The beds would not be working since it requires too much electricity. Staff #69 said that there were two residents that they had to put back on the air mattress after they were able to put everyone that needed on to be on O2. The RN indicated that vital-need equipment were not automatically plugged into the red outlets and that staff had to physically switch out the needed equipment to the red outlets and plug them in. Staff #69 said that one of the residents from the second floor got stuck downstairs until around 11:30 p.m., when the electricity came back. They made sure that the resident had water and that there was a CNA (Certified Nursing Assistant) assigned to that resident. They checked on that resident to make sure that the resident was okay. Staff #69 noted that the alarm did not go off last night regarding the generator. The generator did not kick in. The light went on and off and the doors shut. The RN went to each of the residents' room and informed them that they were there and that the electricity will comb back. Staff #69 said that by the time they left at around 8:30 p.m., it was not hot. However, when they returned on shift at around 7:10 a.m., it was hot. The NOC shift did not talk to them since they were assigned to the first floor. Therefore, they were not aware of anyone taking the temperature in the residents' rooms at night. Staff #69 said that if the resident's room is warm, they are supposed to move the resident to another location and report the issue to maintenance as soon as possible. However, since the facility had no electricity the elevator was not working, so they could not move the residents. The RN said that if you have to check the temperature then it is too late since it is too hot. Elderly people, they do not feel the change quick, you have to recognize if the climate is not okay. When there is an issue staff can call or use the TELS system to submit a work order. For the power outage, the phone call was appropriate response. They got the residents ice. They assumed that the generator would kick in. However, it did not kick in right away. (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Assistant Maintenance Technician (staff #33) conducted on July 15, 2024 at 10:48 a.m., staff #33 stated that they were called in when the power went out to get the generator started. They stated that the Maintenance Director called them at approximately 6:15-6:30 p.m. They arrived at the facility around 6:47 p.m. The Assistant Maintenance Technician noted that when they arrived at the facility, the building was dark and they had to get the generator key and got it going. The generator finally kicked in at about 7:06 p.m. Staff #33 noted that they do weekly test on the generator and run it weekly for 3 hours, take temperature readings, etc. to ensure that it is working. The Assistant Maintenance Technician said that last week, they came by and looked at the generator to see if they were going to disconnect it while they were going to do some work. Staff #33 said that there is no alarm system for the generator. However, for the boilers, when the gas runs low and runs out, an alarm goes off, and it shuts off the pumps to include the one for the chiller which they did not know. The alarm for the boiler went off and you have to go and switch off the alarm, and places on standby, causing the chiller and boiler to automatically shut off. Staff #33 stated that it takes 2-3 hours to get going for the chiller to actually start cooling and get the air conditioner working. The Assistant Maintenance Technician said that this morning, they realized that the AC was not cooling, this was around 5:00 a.m. Last night, they reset the AC before he left at 2:15 a.m. Staff #33 noted that they checked the temperatures in the rooms before leaving and it was averaging 73-78 Fahrenheit upstairs and 72 Fahrenheit downstairs. The Assistant Maintenance Technician stated that it takes time to cool off the rooms. The windows upstairs were open because the staff were trying to keep the residents cool. Staff #33 admitted that they did not document any of the room temperature taken last night. They also noted that each time the pumps go into standby mode, they had to go into each room and reset the AC. The Assistant Maintenance Technician said that when they arrived in the facility this morning and came into the kitchen, they noticed and felt that it was hot. They went upstairs to check the rooms but did not take the temperature. Staff #33 said that it was hot and the residents were sleeping. They commented that the residents could have been moved from the second floor to the first floor where it was cooler. They indicated that the process when it is hot in the facility is to use portable coolers, and noted that there are only 3 portable coolers and they are all being used upstairs. Staff #33 admitted that the elevator was not working in the [NAME] last night when the power outage ended. They stated that they would have moved the residents if it was hot. They noted that they were not sure what the temperature is when residents have to be moved. Staff #33 noted that they used extension cords for red plugs in the hallways since they were not in all rooms. They said that the only things plugged into the red outlet were oxygen and things needed for the resident's health and safety. Staff #33 said that there were no fans in the rooms. They admitted that they are supposed to try and make sure the residents are comfortable as much as possible with the limited resources and old system. They noted that climate control is for the residents' comfort. They indicated that they called the Maintenance Director (staff #32) at approximately 6:12 a.m. and was told that he was on his way and they will all figure it out. Staff #33 recalled that last year, when it last happened last summer, the facility brought all the residents downstairs to the dining rooms. Back then the electricity was out for 2 hours but it was long enough to feel the heat. Staff #33 stated that they saw the Maintenance Director around 7:00 a.m., and both of them went around the rooms. They both agreed that the rooms were hot but did not take temperatures of the residents' rooms. They noted it was hot based on ambient air. Staff #33 stated that it was around 8:00 a.m. when temperatures were taken and it averaged 83? Fahrenheit upstairs and 78 Fahrenheit downstairs. The Assistant Maintenance Technician indicated that they were concerned about the residents being in hot rooms since they are weak and have conditions. Staff #33 noted that neither the Administrator (staff #110) nor the DON (staff #59) asked them about temperatures. They indicated that they were with the Maintenance Director (staff #32) were outside working on the chiller when the DON approached the Maintenance Director to have a conversation but did not know what was discussed. Staff #33 noted that they are trained for fire but admitted there is not an emergency elevator or a plan on how to evacuate residents from the second floor that are not ambulatory. The Assistant Maintenance Technician admitted that they have not done disaster drills. It is a concern how to get residents out and there are a few who are very heavy set. It is the second time the electricity had gone out and they noted that they do not have a standard practice to follow. (continued on next page)

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 07/17/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with a Registered Nurse (RN/staff #50) was conducted on July 17, 2024 at 8:29 a.m. Staff #50 stated that when they arrived on shift the day after the power outage, the none of the residents complained. However, staff #50 said that the rooms felt hot to him. The RN stated that they had not experience a power outage that resulted in the facility being hot. Staff #50 noted that the protocol when a resident's room is hot is for them to move the resident to a cooler room. The RN said that there are guns (thermometer) on the cart that are used to check room temperature. However, it was unknown whether the temperature for the rooms were taken. An interview with the Administrator (staff #110) was conducted on July 17, 2024 at 1:09 p.m. Staff #110 stated that a comfortable environment for residents is part of homelike environment. Residents should have areas to rest, congregate, have a sense of peace, and lack of chaos. The Administrator stated that the impact on residence if the facility is not comfortable with regards to temperature is that it could influence sleep hygiene, quality of sleep, and rest. It could influence maintaining proper hydration. Could for disturbing for one's ability to rest comfortably.

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 07/17/2024
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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that initial and ongoing weights were conducted for one resident (Resident #36). The deficient practice could result in a change of condition not being assessed and monitored. Findings include: Resident #36 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, Parkinson's disease and chronic respiratory disease. Review of the clinical record revealed that the resident weighed 187 pounds on February 9, 2024. Review of the nutritional assessment dated [DATE] revealed that the resident was malnourished. The care plan dated February 22, 2024 revealed that the resident was at risk for weight fluctuation related to dysphagia and anoxic brain injury. Interventions included eternal feeding as ordered and weight as per the facility policy. The minimum data set (MDS) dated [DATE] included a staff assessment for mental status score of 2 indicating the resident had moderate cognitive impairment. The clinical record revealed that the resident weighed 168.6 pounds on June 4, 2024 and 167.4 pounds on July 2, 2024. An interview was conducted on July 17, 2024 at 10:07 a.m. with a Registered Dietician (staff #66), who stated that a nutritional assessment is done when residents are admitted and all residents are supposed to be weighed. He stated that resident #36 was not weighed when he was admitted to the facility and the weight documented in the clinical record was taken from the weight documented in the hospital transfer records. He also stated that the resident should have been weighed monthly as per the facility policy in order to assess and monitor weight loss, fluctuations, fluid shifts, and if a weight change has occurred, so the root cause can be determined. He stated that there is a risk of developing malnutrition and/or congestive heart failure (CHF) fluid retention not being recognized if weights are not being monitored. An interview conducted on July 17, 2024 at 11:15 a.m. with the Director of Nursing (DON/staff #59), who stated that the facility policy states that all residents are supposed to be weighed weekly for the first four weeks and then monthly. The reason for weighing the resident is to check for significant weight loss or gain. She stated that when the resident was admitted , the certified nursing assistant (CNA) should take the resident's initial weight and should not use the recorded weight from the hospital records because the weight may not be accurate. She stated that they just recently talked about weighing hospice patients, and all residents should be weighed. The facility addendum to the Lippincott procedure revised August 21, 2023 states that measuring a patient's weight is part of a routine admission to a health care facility. An accurate record of the (continued on next page)

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 07/17/2024
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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient's weight is essential for calculating dosages of drugs, fluid maintenance, anesthetics, and contrast agents; calculating tidal volume in patients requiring mechanical ventilation; assessing the patient's nutritional status; and determining the patient's height-weight ratio, body surface area, and body mass index (BMI). The facility policy, Weights and Heights reviewed August 23, 2023 states that all residents are weighed within 24 hours of admission and weekly for 4 weeks and as needed thereafter or more as determined by the RAR committee and/or physician order.

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 07/17/2024
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)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 40581 Based on observation, a staff interview, and the facility policy and procedures, the facility failed to ensure that the daily staff posting included the correct information. Findings include: On July 14, 2024 at approximately 9:00 a.m. the daily staff posting was observed hanging on the wall just to the left of the reception desk. The information observed on the posting was: -July 12, 2024 -census 60 -number of each type of staff for each shift -the total hours scheduled for each type of staff for each shift -the actual hours worked was not completed During this time the Director of Nursing (DON/staff #59) approached and removed the daily staff posting dated July 12, 2024 and stated that she was just about to the change it. Review of the facility documentation revealed that the census was 58 on July 14, 2024. An interview was conducted on July 17, 2024 at 11:30 a.m. with the (DON/staff #59), who stated that the Central Supply Director/staffing coordinator (staff #95) is responsible for completing daily staff posting and works Monday through Friday. She stated that staff #95 prepares the daily staff postings for the weekend and the weekend receptionist is supposed to switch them out. She stated that the posting is for visitors and residents to see how many staff are available in the building. The facility policy, Facility Staffing Posting revised December 13, 2023 states that the facility needs to post nurse staffing information in a prominent place where it is accessible to residents and visitors. The data should be clear, readable, up to date and current. When listing the total number of staff and actual hours worked, the facility is required to reflect staff absences on each shift that occur due to callouts or illness. The nurse staffing data needs to be posted on a daily basis at the beginning of each shift. The required information that needs to be posted includes: I. Facility name 2. Current date 3. Resident census 4. Total number of staff and actual hours worked per shift for: (continued on next page)

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 07/17/2024
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)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Registered Nurses b. Licensed Nurses c. Certified Nurse Aides

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 07/17/2024
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47954 Based on observations, staff interviews, and policy, the facility failed to ensure multiple food items were stored at safe temperatures in accordance with professional standards. This deficient practice could result in placing residents at risk for food-borne illnesses. The facility census was 58. Findings include: During an initial observation of the kitchen, conducted at 8:25 a.m. on July 14, 2024 with staff #15. In the walk-in refrigerator, the thermometers both inside and out registered a temperature displaying 45 degrees Fahrenheit (F). Inside the refrigerator were various food items including milk, eggs, yogurt, meat, cheese, and dressings. Staff #15 stated the temperatures are recorded on the log twice daily, morning and evening. Review of the monthly temperature log for July 2024 revealed the morning refrigerator temperature on July 14, 2024 was recorded at 36F. The evening temperature was recorded at 40F. The log includes a critical limit (CL) for temperature at 40F on the high end, and revealed that in the event of a temperature not within the required range, to notify the Director of food services or maintenance immediately. During a kitchen observation conducted on July 15, 2024 at 10:12 a.m. of the same walk-in refrigerator, the external thermometer and internal thermometer registered a temperature displaying 42F. Review of the monthly temperature log for July 2024 revealed the morning refrigerator temperature on July 15, 2024 was recorded at 37F. The evening temperature was recorded at 40F. During a kitchen observation conducted on July 16, 2024 at 9:30 a.m. of the same walk-in refrigerator, the external thermometer registered a temperature displaying 50F. The internal thermometer registered a temperature displaying 44F. A second observation was made on July 16, 2024 at 11:50 a.m. The external thermometer again showed a temperature displaying 50F, and the internal thermometer displayed a temperature of 44F. Review of the monthly temperature log for July 2024 revealed the morning refrigerator temperature on July 15, 2024 was recorded at 38F. The evening temperature had not been recorded yet. An interview was conducted on July 16, 2024 at 12:35 p.m. with a cook (kitchen staff #40). The cook stated that most of the foods served for meals are stored in the walk-in refrigerator, including prep stuff for the next day, thawing meat, dairy and milk, as well as cottage cheese. The cook also stated that left overs are also stored in the same walk-in. The cook stated that temps in the walk-in need to be 39F or below, and that temperatures are recorded using the outside thermometer twice daily in the monthly log. (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	07/17/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on July 16, 2024 at 12:44 p.m. with the Registered Dietician and Kitchen Manager (RD/kitchen staff #66). The RD stated that temperatures need to be under 40F in the walk-in or it puts the food at risk of causing food-borne illness such a botulism. The RD stated that all refrigerated items used in the facility are stored in that walk-in, including dairy, cheese, eggs and leftovers. The RD further stated that he was aware of a door being replaced on the freezer for a temperature issue, but was not sure about the walk-in. During this interview the RD removed two random containers of food product from the walk-in refrigerator and took the temperature of them. A single serving yogurt container, and a jar of Mayonnaise. The temperature of both items was measured by the RD at 45F. An interview was conducted with the Maintenance director (Facility/staff #32) on July 16, at 1:25 p.m. The Maintenance director stated that there was a mistake with what the temperature was set at in the walk-in refrigerator. He stated that the walk-in was accidently set to 40F by mistake when it was being worked on, roughly one month ago. He further stated that the outside thermometer on the walk-in was broken, and does not register temperatures correctly. However, the facility logs showed multiple entries for the month of July with temperatures ranging from 32F and 40F. An interview was conducted with the Executive director (ED/staff #110) on July 17, at 11:50 a.m. The ED stated they were aware of the food issue and it was being corrected. The ED further stated that her expectation is that food is stored safely, an that thermometers will be calibrated correctly going forward. Review of the facility policy titled 'Food Safety' revised April 26, 2023 and reviewed May 1, 2024 revealed that it is the policy of the facility to ensure food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. It further revealed that the danger zone means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F allow the rapid growth of pathogenic microorganisms that can cause foodborne illness.

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 07/17/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40581 Based on employee record review, staff interviews, and the facility policy and procedures, the facility failed to ensure that one staff (#110) was free of tuberculosis (TB) prior to working in the facility. The deficient practice could result in residents being infected with tuberculosis. Findings include: Staff # was hired as the Administrator (staff #110) for the facility on January 8, 2024, During an interview conducted on July 16, 2024 at 1:56 p.m. with the accounting clerk/human resources personnel (staff #73), she stated that (staff #110) did not provide a current TB test for herself. She stated that the Executive Director is probably supposed to have a TB test prior to working in the building. She stated that the reason for testing is to prevent the risk of TB spreading throughout the building. An interview conducted on July 17, 2024 at approximately 9:50 a.m. with the (staff #110), who stated that she did not have a tuberculosis test prior to working in the facility. She stated that she was tested yesterday, July 16, 2024, and the test results had not been read. An interview was conducted on July 17, 2024 at 11:19 a.m. with the Director of Nursing (DON. /staff #59), who stated that when a person is hired, he/she is required to show a test result for TB is negative prior to working in the facility. She stated that the administrator (staff #110) walks the floors of the building and should do daily. She doesn't interact directly with residents, but follows up with residents as needed. She stated that staff #110 can come into contact with residents when she is walking the halls. The facility policy, Tuberculosis - Testing and Screening revised June 28, 2024 states that the facility will evaluate each associate and volunteer for tuberculosis in accordance with current CDC guidelines, unless more stringent guidance is provided by local or state regulation. New associates or volunteers who have been made a conditional offer shall be screened for presence of infection through the following measures; pre-placement risk assessment and symptom evaluation and the facility should also perform skin test for M. Tuberculosis using the Mantoux TST skin test.

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 07/17/2024
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)
F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough power supply for lighting all entrances and exits; equipment for fire detection and alarm systems, and extinguishers. 47669 Based on record review and staff interview the facility failed to ensure the emergency and standby power systems were functioning properly. Failure to implement an emergency and standby power systems plan during an emergency could lead to harm of the patients and/or staff. Findings include: Based on record review and staff interview on July 17-18, 2024, the facility failed to ensure the emergency generator was adequate for the facility needs during an emergency. The facility has had a rental generator since March 2, 2020. On July 14, 2024 the facility experienced a power failure and the temporary generator failed to turn on leaving the facility totally without power. Medical equipment, the elevator and facility walk-in refrigerator and freezer were none functioning during the total outage. The following are staff interviews: Monday, July 15, 2024, at approximately 0941 hours an interview was conducted with staff # 32, Maintenance Director. Staff #32 stated that he was notified at 1815 hours on July 14, 2024, that the power was out. Staff #32 stated that he responded to the facility arriving at 1845 hours. Staff # 32 further stated that the facility was dark and the staff were panicking. Staff # 32 stated that he began troubleshooting and found that the main breaker for the facility had popped and that he reset it. Staff #32 further stated that it took approximately one hour to troubleshoot and that the generator was manually started between 1945 and 2000 hours. Staff # 32 stated that the chillers were not active as they drew too much voltage. Staff # 32 stated that When he arrived at the facility on July 15, 2024, he was unaware that the circular pumps were off. Staff # 32 stated that he later learned that staff #33 had bypassed the circular pumps because he had turned the alarm had been turned off. Staff# 32 stated that had the alarm been on he would have known there was an issue with the circular pumps. Staff #32 stated that at 0700 hours on July 15, 2024, they had to go through the facility and reset all of the AC units. Monday, July 15, 2024, at approximately 1010 hours an interview was conducted with staff # 69, RN unit nurse. Staff # 69 stated that the electricity went out between 1820 and 1830 hours on July 14, 2024. The residents that were on oxygen concentrators had to be switched to O2 tanks due to the electricity being out. Staff #69 stated that the alarm did not go off last night regarding the generator. Staff # 69 further stated that with the electricity being out he knew that the doors needed to be watched to prevent any elopement. Staff # 69 stated that if the resident rooms are hot they should begin moving residents immediately however, if the electricity is out the elevators would not work so they would not be able to move the residents. Staff # 69 stated that he was assuming the generator would kick in right away, but that it did not, and this is why they called maintenance. (continued on next page)

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 07/17/2024
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)
F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monday, July 15, 2024, at approximately 1048 hours, Staff # 33 was interviewed. Stated that the power had gone out the previous night, July 14, 2024. Staff # 33 stated that he received a telephone call from Staff # 32, Maintenance Director sometime around 1810-1815 hours on July 14, 2024, and asked him to respond to the facility. Staff # 33 stated that he arrived at the facility around 1847 hours and saw that the facility was all dark. Staff # 33 stated that the generator had not kicked on right away and estimated that the generator got going between 1906 and 1910 hours. Staff # 33 further stated that when the power goes off, the gas shuts off for safety reasons and this turns the pumps off to include the chiller system. Staff # 33 stated that he and staff # 32 were in the boiler room around 0500 hours on July 15, 2024, and realized the air conditioning was not cooling. Staff #33 stated that he noticed the heat when he came in at 0500 hours on July 15, 2024, and noticed the kitchen was hot and rechecked the rooms. Stated that he noticed the rooms were hot but did not re-temp them at that time. Stated that he thought the residents should be moved to a place that was more comfortable. The west elevator was working last night when the lights came back. The north elevator was not working. Stated that no discussion of moving residents last night. Stated that residents could have been moved last night. Stated that some units were still functional, but because of auxiliary pump the residual water was allowing for a few units to work. Stated that he did not know at what temp residents should be moved. Stated that extension cords were running into the rooms. All red plugs are in the hallway. There are no red plugs in the rooms. Staff # 33 stated that there is no standard practice to handle a power outage. Stated that in all the time that he has been there, there have been no mock disaster drills. Stated that he had brought concerns up to staff #32 regarding what they would do, especially with the heavier residents. The findings were confirmed by staff #32 and #110 during the exit conference conducted on July 18, 2024. The first day the facility was on a temporary generator was March 2, 2020 per the rental contract the facility provided. The life safety code portion of this survey started July 17, 2024. 1598 days is the distance between the two dates. Which is 4 years, 4 months and 15 days.

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 07/17/2024
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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on observations, staff and resident interviews, and the facility's documentation and policies, the facility failed to ensure a safe and comfortable environment for residents: Findings include: Regarding safe environment: During the initial walk-through observation of the facility conducted on July 14, 2024 at 10:11 a.m., the following was observed: - Doorway frame missing in room [ROOM NUMBER], light brown paint is peeling, exposing the green pain underneath. It felt rough to the touch. - Corner handrail by room [ROOM NUMBER] was rough with gouges and the edges felt sharp enough to scratch/tear skin during an unintended contact. - Numerous doorframes on the second-floor hallway had paint peeling and has gouges that were sharp to the touch. - Numerous handrails on the second floor was rough with gouges that are rough/sharp to the touch. - Second floor nurse's station corner had a nail sticking out on the bottom corner. That same bottom corner had gouges that were rough to the touch. - Corner handrail on the second floor by the stairway had 4 screws sticking out. Additionally, the handrail had gouges and was sharp/rough to the touch In a follow-up wall-through conducted on July 17, 2024 at 8:53 a.m., the following was observed: - Numerous handrails on the second floor was rough with gouges that are rough/sharp to the touch. - Numerous doorframes on the second-floor hallway had paint peeling and has gouges that were sharp to the touch. This included shower doorframe. - Corner handrail by room [ROOM NUMBER] was rough with gouges and the edges felt sharp enough to scratch/tear skin during an unintended contact. - Corner rail by soiled utility on the second floor had a metal brace that was slightly sticking out. - Second floor nurse's station corner still had a nail sticking out on the bottom corner. That same bottom corner had gouges that were rough to the touch. (continued on next page)

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 07/17/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Below the handrail next to linen room on the second floor by room [ROOM NUMBER] had a metal brace on the wall corner that is slightly sticking out. That same corner has pieces of the wall corner with severe gouges that is rough/sharp to the touch. - Corner entry to wall to room [ROOM NUMBER] had a metal brace that was coming off the wall and the wall corner had severe gouges that was rough/sharp to the touch. - Inside entry wall right hand side in room [ROOM NUMBER] has long deep gouges on the lower wall above the baseboard. - Corner handrail on the second floor by the stairway no longer had the 4 screws sticking out. However, the handrail had gouges and was sharp/rough to the touch. An interview with a Registered Nurse (RN/staff #50) was conducted on July 17, 2024 at 8:29 a.m. Staff #50 stated the process for submitting work orders is that they can either use the book, the app, or call the emergency number for maintenance for whoever is on call. When asked about the overall status of the hallways/residents' living area, the RN noted that the place could use a lot of TLC (tender loving care). Staff #50 noted that to their knowledge maintenance had never asked staff or residents' input regarding what needs to be done. The RN indicated that like the staff, the residents have just come to accept the overall appearance/status of the facility. However, it would be nice to make the area more presentable, a little bit more modern. An interview with the Maintenance Director (staff #32) was conducted on July 17, 2024 at 9:34 a.m. Staff #32 noted that works orders are submitted by residents by informing the nurses and/or staff who in turn submit work orders via TELS system. The Maintenance Director noted that the turn around time for work orders depends on the required work. Usually the priority are those work orders related to call lights, O2 (oxygen) tanks or anything related to resident safety. For work orders tagged as priority, maintenance resolves them no more than 24-hours. Other work orders such as painting, normally takes 2-3 days to close out. Staff #32 stated that there are no current plans for updates to halls or rooms per corporate. The Maintenance Director indicated that they conduct walk-throughs on Mondays and take care of the issues. A walk-through with the Maintenance Director (staff #32) was conducted on July 17, 2024 at approximately 9:56 a.m. to look at the identified observations above. Below are staff #32's comments: - room [ROOM NUMBER]'s long deep gouges on the lower wall above the baseboard-noted that it is not very homelike - handrail by room [ROOM NUMBER] with a metal brace on the wall corner - indicated that it was not noticed before but is a concern since it is metal - shower doorframe on second floor - noted that it is a concern since there are metal components - room [ROOM NUMBER] - indicated that it is a concern since the metal brace came off as we were inspecting it (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	07/17/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- nail sticking out at nurse's station was no longer there, a photo from the entrance day and earlier in the morning sticking out was shown to staff #32 - he noted that it is a concern since someone could get hurt with it. A follow-up interview was conducted with the Maintenance Director (staff #32) on July 17, 2024 at approximately 10:15 a.m. Staff #32 stated that in their opinion, the facility is livable, but some of the identified harm during our walk-through puts it at 75% homelike. Whether they gets all the things fixed, it is a routine and it will get messed up again. The Maintenance Director said that it is hard to maintain but it is livable and that if residents were asked, the residents would say it is okay. Staff #32 said that during their walk-through, they identify what can damage residents and staff, prioritize it and fix it. However, if nobody says anything, and they are not aware, they it cannot be fixed. The Maintenance Director said that it is important for the facility to be safe and comfortable so residents and their families are happy and to make it better for the residents. An interview with the Administrator (staff #110) was conducted on July 17, 2024 at 1:09 p.m. Staff #110 stated that the expectation is that the living area for resident are clean, free of obstruction and without significant odors. The facility is to be clean and safe from hazards. Staff #110 stated that repairs should be maintained to have a homelike environment such as paint and upkeep. The Administrator stated that this is important since this is the home for people living here and they deserve a good quality of life. It has to be safe so that residents are not put at risk for accidents or injuries. Staff #110 stated that the impact if the facility is not homelike and safe is that residents might feel discomfort, might reduce the homelike environment feel until things were repaired, it could provide a risk for some type of injury i.e. if legs extend beyond the wheelchair there could be a risk of injury. Review of the open work order report generated on July 15, 2024 did not reveal any work order pertaining to any of the issues identified during the walk-through observations. Review of the facility policy titled Preventive Maintenance Program revised January 11, 2023 and reviewed January 22, 2024 indicated that the facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. The facility policy titled Work Request System revised May 14, 2019 and reviewed January 15, 2024 indicated that the work order request system was designed to provide an established and effective means of requesting, coordinating, and completing maintenance of a corrective nature. A facility policy titled Resident Rights issued June 8, 2020 and reviewed September 25, 2023 indicated that resident has a right to safe, clean, comfortable, and homelike environment.

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 07/17/2024
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)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 40581 Based on employee record review, staff interviews, and the facility policy and procedures, the facility failed to implement and maintain an effective training program for annual training: abuse, resident rights, infection control, dementia training, and emergency preparedness for multiple staff (#50, #26, #43, #54, #38, #59, #32 and #110). The deficient practice could impact the safety, rights, and care provided to residents. Findings include: Review of the employee records for a registered nurse (RN/staff #50) revealed that abuse training was completed on June 15, 2022, completed resident rights on February 27, 2023, infection control training on June 15, 2022, and there was no documentation for emergency preparedness. -Review of the employee records for (RN/staff #26) revealed that abuse training was completed on October 6, 2022, resident rights completed on March 31, 2023, infection control completed on January 27, 2023, and emergency preparedness was competed on January 27, 2023. -Review of the employee record for Licensed practical nurse (LPN/staff #43) revealed that abuse training was completed March 9, 2022, resident rights completed on May 25, 2022, infection control completed May 31, 2022, and there was no documentation for emergency preparedness. -Review of the employee record for (LPN/staff #54) revealed that abuse training was completed on January 2, 2023, resident rights was completed on January 2, 2023, infection control was completed on February 20, 2023, dementia care January 3, 2023, and there was no documentation for emergency preparedness. -Review of the employee record for a Certified nursing assistant (CNA/staff #38) revealed that abuse training completed on October 18, 2022, resident rights October 18, 2022, infection control June 20, 2022, dementia training completed on October 18, 2022, and emergency preparedness was not attempted. -Review of the employee records for The Director of nursing (DON/staff #59) revealed that abuse training was completed on June 29, 2022, resident rights training was not attempted, infection control was not completed, emergency preparedness was not attempted. -Review of the employee records for the Maintenance Director (staff #32) revealed that abuse training, resident rights, infection prevention, and dementia care were not attempted. -Review of the employee records for Administrator (staff #110) revealed no documentation for abuse training, resident rights was not attempted, infection control was not attempted, and emergency preparedness not attempted. (continued on next page)

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 07/17/2024
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)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on July 16, 2024 at 1:56 p.m. with the human resources accounting clerk (staff #73), who stated the corporate office usually sends an email when training needs to be done. She stated that all staff, including the Administrator, are required to complete emergency preparedness, resident rights, abuse, infection control, and dementia training annually and the training are due based on the the staff's date of hire. An interview was conducted on July 16, 2024 at 3:33 p.m. with (staff #110), who stated that all the staff are required to complete the training annually, but not all the staff had completed emergency preparedness. She stated that they have printed up most of the current training for the ten employees. An interview was conducted on July 17, 2024 at 11:19 a.m. with (DON/staff #59), who stated that she has a policy on required annual training for staff: infection control, abuse, resident rights, dementia, emergency preparedness. She stated that the training due date is based on the date of hire and everyone, including the Administrator, are supposed to complete the training. The facility policy, Yearly Required Training: states that a facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. Each associate will be provided the following core educational content annually through the learning management software that will be part of a curriculum titled Annual General Requirements Curriculum. Each associate will need to complete the courses individually by the due date provided in the course assignment page. Core education includes: infection prevention and control, emergency preparedness, resident rights, abuse, but did not include dementia care.