

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/10/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, review of facility documentation, clinical records and facility policy, the facility failed to ensure that one resident (Resident #15) out of one sampled resident was free from preventable accident by failing to ensure appropriate safety measures during a transfer. The universe was sixty. The deficient practice could place other residents at risk for preventable falls and serious injury. Findings include: Resident #15 was admitted to the facility on [DATE], with multiple diagnoses that included a historical fracture of the right shoulder girdle and need for assistance with personal care. The quarterly Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview for mental Status (BIMS) score of 14 indicating intact cognition. Review of the MDS also revealed that the resident required substantial assistance with transfers from the bed to the chair. The care plan initiated on January 30, 2026 revealed a focus area related to a risk for falls, with intervention that included assistance with activities of daily living (ADLs) as needed. Further review of the care plan initiated on January 30, 2026 revealed a focus area related to ADLs with interventions to include that the resident required two-person dependent assistance with transfers. A health status note dated April 22, 2026 at 10:30 P.M., revealed that during a two-person-assisted transfer from the wheelchair to the bed, the resident fell because the bed brakes were unlocked. The fall resulted in the resident being sent to the hospital for a suspected shoulder fracture and pain. Review of emergency department documentation, dated April 22, 2026, revealed x-ray results that indicated a displaced spiral fracture of the proximal humeral shaft. Following the incident, a care-plan initiated on April 28, 2026 revealed a focus area related to alteration in musculoskeletal status related to chronic right humeral fracture, with interventions that included following provider orders for weight bearing status and following up with an orthopedic provider. A pre-surgery progress note dated May 5, 2026 revealed details regarding a scheduled surgery for the resident related to a right displaced humerus fracture. A physician order dated May 8, 2026 revealed an order for the resident to remain non-weight bearing on the right upper extremity following the right humerus fracture. An interview was conducted on July 8, 2026 at 1:09 P.M., with a Certified Nursing Assistant (CNA/ Staff #23). Staff #23 stated that a transfer of a resident included checking that the bed is locked prior to completing the transfer. An interview was conducted on July 8, 2026 at 2:47 P.M., with a CNA (Staff #110). Staff #110 stated that the process for transfers included using a gait belt for support, and ensuring all brakes on the bed and chair are locked. Staff #110 stated that the risks associated with not ensuring the brakes are locked include the resident falling. Staff #110 further stated that if the brakes are not locked, there is a chance for both the resident and staff member to fall. An interview was conducted on July 8, 2026 at 2:56 P.M., with Resident #15. Resident #15 stated when resident #15 was being assisted to transfer from her wheelchair to her bed, she fell as a result of the bed (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 035140	Facility ID: 035140 If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Actual harm Residents Affected - Few	brakes not being locked. She recounted Staff #14 and Staff #102 assisted her, and stated that both staff members were standing too far away to assist her adequately. Resident#15 stated that staff would normally assist her by holding on to the seat of her pants in replace of using a gait belt to assist her to stand and transfer. Resident #15 recalled reaching towards the bed, and the bed rolling away from her so that she fell forward on her shoulder. Resident #15 stated she heard a pop in her shoulder and cried out in pain. Resident #15 stated that she felt the incident was both accidental and neglectful. She further stated that the fall could have been prevented. An interview was conducted on July 9, 2026 at 11:24 A.M., with a CNA (Staff #14). Staff #14 stated that she was one of the CNAs assisting Resident #15 to transfer. Staff #14 further stated she was present during the fall, and she had been informed that the resident required only supervision during transfers, despite the resident's care plan indicating she required two-person dependent assistance. Staff #14 further stated that she supervised the transfer from wheelchair to bed, and that the bed brake was unlocked. Staff #14 stated that the process for transfers included ensuring that all the brakes are locked prior to the transfer being completed. Staff #14 further stated that she did not check the brakes on the resident's bed because she assumed they would be locked. She further stated she should have checked the brakes. An interview was conducted on July 9, 2026 at 11:53 P.M., with a CNA (Staff #102). Staff #102 stated that she was also present during the fall. Staff #102 stated she was assisting Staff #14 to transfer Resident #15 to the bed. Staff #102 stated that the resident stood to transfer, reached for the bed, the bed rolled forward, and the resident fell forward. Staff #102 stated that she should have checked to ensure the brakes were locked, but had not. She further stated that both she and Staff #14 were at fault. An interview was conducted on July 9, 2026 at 1:32 P.M. with an Occupational Therapist (OT/Staff #121). Staff #121 stated that safety during transfers included using gait belts, and that it would be inappropriate for the wheels on beds or chairs to be unlocked during a transfer. Staff #121 further stated that therapy staff and CNAs are trained on appropriate transfers. A follow-up interview was conducted on July 9, 2026 at 2:27 P.M. with Staff #102. Staff #102 stated she had personal documentation of the incident. Review of the handwritten witness account from Staff #102 recounted that on April 22, 2026, the resident fell onto the bed, on her right arm, and the resident yelled out that she broke her arm. The witness account revealed the resident was sent to the hospital immediately following the incident. An interview was conducted on July 10, 2026 at 8:38 A.M., with a Licensed Practical Nurse (LPN/ Staff #67). Staff #67 stated that during a transfer, the bed and chair should be checked to ensure the brakes are locked. Staff #67 further stated that not checking that the brakes were locked on Resident #15's bed is not an accidental action. An interview was conducted on July 10, 2026 at 10:41 A.M., with the Director of Nursing (DON/ Staff #3). Staff #3 stated that the resident fell on her bed during a transfer and was sent to the hospital. Staff #3 stated that the resident was diagnosed with an acute fracture. Staff #3 further stated that the resident was referred to orthopedic services, and was deemed to need surgery. Staff #3 stated that the bed brakes were not locked during the transfer. Staff #3 stated that the process for transferring a resident included ensuring the resident is able to transfer, then checking that the chair and bed brakes are locked. A review of the staff file for Staff #14 revealed that the staff member completed an annual skills competency on April 23, 2026, including transfers. Staff #14 was marked as competent in this skill. A review of the staff file for Staff #102 revealed that the staff member completed an annual skills competency on April 24, 2026, including transfers. Staff #102 was marked as competent in this skill. Facility policy, titled Area Focus: Fall Management, reviewed December 3, 2025, revealed the purpose of the policy included ensuring each resident received adequate supervision to prevent accidents. Further review revealed this included that a comprehensive care plan would be developed and (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	initiated to include a resident's fall risks. Facility policy, titled Activities of Daily Living (ADLs), reviewed September 10, 2024, revealed that staff should utilize appropriate safety measures to maintain resident safety related to any bed or chair mobility.		