

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 09/18/2025
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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate assessment, monitoring, and supervision to prevent elopement for one of the 5 sampled residents. The deficient practice could result in injury to residents. Findings Include: Resident #119 was admitted to the facility on [DATE], with a diagnoses of Essential (primary) hypertension, hyperlipidemia, unspecified severe protein-calorie malnutrition, chronic kidney disease, stage 3, chronic obstructive pulmonary disease, anemia, nonrheumatic aortic (valve) stenosis, occlusion and stenosis of left carotid artery, nonrheumatic aortic (valve) insufficiency, dysphagia following cerebral infarction. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 4, indicating moderate cognitive impairment. The elopement assessment was assessed as not a risk for the resident (#119). According to the progress notes dated August 25, 2025, it was revealed that the resident became confused at intervals and wandered out into the hall. As per the Elopement risk evaluation dated August 28, 2025, the resident is identified as at risk for elopement, and the following interventions were placed: Add the resident to the Elopement book (This will be at all the nursing stations and with the receptionist), encourage participation in activities to divert from exit-seeking behavior. The Elopement risk assessment further revealed that the interventions have been initiated, reviewed, or modified, and appropriate physician orders have been requested. obtained, family / responsible party/resident has been notified, and the care plan has been updated. The resident's picture, along with his room number and risk for elopement, was added to the yellow binder, which is referred to as the Elopement book. One of these books is also located at the reception area. Nursing progress note August 30, 2025, at 4:49 p.m. revealed that at 3:35 p.m. that resident #119 was missing. The patient was previously seen by this nurse about 30 minutes prior in the west hall, wearing a red shirt and blue pajama pants. Staff immediately began to conduct a facility room search. The area was searched around the building. 911 was notified, as well as the resident's sister. The DON and Administrator were also notified. A sheriff deputy found the resident at a nearby store. The resident was checked out by EMS and brought back to the building. An interview was conducted with the LPN # 36 on September 17, 2025, at 4:00 PM, which revealed that the residents are evaluated for elopement risk upon admission. Residents are assessed for elopement risk using the Yellow Book, which lists those prone to wandering; a copy is kept at the front desk. Staff review the book at the start of each shift and check on at-risk residents. If a resident shows exit-seeking behavior, staff intervene with redirection, initiate 15-minute checks for 72 hours, and notify the physician, psych team, and family. In the event of an elopement, the physician, family, and police are alerted. There are no Wander Guards in place; monitoring and 15-minute checks are the primary interventions. Residents with a BIMS score of 4 require close supervision, with hourly checks recommended due to poor cognition and safety awareness. Staff #35 further stated that she was aware of a recent elopement incident through messages, but she was not on duty that weekend. Of the four facility entrances, two are locked after 4 PM, and the others require a security code to exit. An interview was conducted with the CNA # 22 on September 17, 2025, at 4:41 PM revealed that the staff monitor residents assessed for elopement risk using a yellow binder and conduct 15-minute checks for those listed. The CNA # 22 further stated that she was present when the resident was admitted and stated that the resident # 119 understands conversations but has limited communication ability. He frequently walked around his room and occasionally entered others' rooms, requiring redirection-prompting the start of 15-minute checks. Initially, he wasn't considered at risk, but his status changed after a week following reassessment. I was informed that he exited the facility through the front door one weekend after 4 PM, reportedly assisted by the receptionist. I believe wander guards could help prevent such incidents. An interview was conducted with the Director of Nursing (DON / Staff # 100) on September 17, 2025, at 6:12 PM. It was revealed that Residents are assessed for elopement risk upon admission, and staff monitor for wandering during daily rounds. The Elopement Book, containing resident photos and demographics, is kept at all nurse stations and the front desk. The receptionist, on duty from 8:00 AM to 4:30 PM, monitors the front door. According to the AD's interview, the recent incident involved a resident exiting through the front door. Initially, the resident was not at risk, but following a significant condition change on August 28, 2025, an assessment identified him as high risk, and the care plan was updated. However, a subsequent assessment on September 2, 2025, overrode this update, and the change was not reflected in the conference care plan. The facility maintains a yellow binder for residents on</p>		