STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035249	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens Rehab & Care Center	3131 Western Avenue Kingman, AZ 86401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that resident (#30) was not abused by resident (#2). The deficient practice could result in residents being harmed emotionally and physically. Findings include: Resident #30 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, chronic kidney disease, encephalopathy, and hypertension. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a moderate cognitive impairment. A progress note dated January 30, 2024 revealed that residents were interviewed and notified appropriate agencies as per protocol. Resident #30 made an allegation of abuse to his therapist. The therapist alerted administration and this nurse at 3:10 p.m. and an investigation was started immediately. The responsible party, the resident's mother, was present when the resident was interviewed at 3:15 p.m. A psych consult was ordered for psychosocial well-being. A care plan dated January 30, 2023 revealed that resident #2 was involved in an allegation of abuse. Interventions included to order a psych consultation related to psychosocial well-being. A skin assessment dated [DATE] did not reveal any injuries. -Resident #2 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure, post traumatic stress disorder, and Rhabdomyolysis. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 5 indicating the resident had a severe cognitive impairment. The care plan dated January 6, 2023 did not reveal a plan for behaviors or PTSD. The progress note dated January 27, 2023 revealed that the resident had a verbal altercation with his roommate. The resident was moved to room [ROOM NUMBER]. The power of attorney is aware. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated January 30, 2023 revealed that the resident was involved in an allegation of abuse. Administration and this nurse were notified at 3:10 p.m. and an investigation was started immediately. The appropriate parties were notified and a psych consult was ordered. A care plan dated January 30, 2023 revealed that resident #2 was involved in an allegation of abuse. Interventions included to order a psych consultation related to psychosocial well-being. The progress note dated January 30, 2023 revealed that the resident was moved to another room per his request. A skin assessment dated [DATE] did not reveal any injuries. Review of the 5-day investigation dated February 3, 2023 revealed: -a physical therapy assistant (staff #21) informed the nurse that resident #30 was inquiring about the altercation that took place him and his roommate. The staff informed the administrator on January 30, 2023 and started an investigation immediately by interviewing the two residents. - a certified nursing assistant (CNA/staff #9). Staff #9's statement revealed that on January 27, 2023, dietary staff (#62) reported to her that two residents were arguing and when she entered the room, resident #2 was close to resident #30's bed, and she heard resident #2 tell resident #30, if I ever get my hands on you, you're a dead man. The argument appeared to be over something on the TV. Staff #9 took resident #2 out of the room to avoid further arguing. -a statement from the dietary staff (#62), which stated that staff #62 worked on January 27, 2023 when resident #30 told staff #62 to come to his room because his roommate was threatening him. Staff #62 notified staff #9. -a psych evaluation for resident #30 dated February 3, 2023 where resident #30 stated that he was watching a TV program about a black man being assaulted by the police and resident #2 called him a n*****, n***** lover and said he would come over and kill him, beat him up. -a psych evaluation for resident #2 dated February 30, 2023 revealed that resident #2 stated that he was in bed and then that he did not remember going over to the resident 30's bed, threatening to kill him, or kicking the bed. An interview was conducted on November 19, 2024 at 11:58 a.m. with the Director of Nursing (DON/staff #1), who stated that she has received training on abuse which includes verbal abuse. She stated that verbal threats to harm with intimidation is a form of verbal abuse along with racial slurs, such as, n***** and n***** lover. During the interview, staff #1 reviewed the 5-day investigation dated February 3, 2023, which included a statement from: -a certified nursing assistant (CNA/staff #9). Staff #9's statement revealed that on January 27, 2023, dietary staff (#62) reported to her that two residents were arguing and when she entered the room, resident #2 was close to resident #30's bed, and she heard resident #2 tell resident #30, if I ever get my hands on you, you're a dead man. Staff #1 stated that this was a threat and considered it verbal abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a statement from the dietary staff (#62), which stated that staff #62 worked on January 27, 2023 when resident #30 told staff #62 to come to his room because his roommate was threatening him. Staff #62 notified staff #9. -a psych evaluation for resident #30 dated February 3, 2023 where resident #30 stated that he was watching a TV program about a black man being assaulted by the police and resident #2 called him a n*****, n***** lover and said he would come over and kill him, beat him up. Staff #1 stated that it sounded like resident #2 was set off by the news that resident #30 was watching on TV. An interview conducted on November 19, 2024 at 2:43 p.m. with the certified nursing assistant supervisor (CNA/staff #17), who stated that she has received training on abuse and verbal abuse includes cussing, name calling, derogatory comments, and threats. The facility policy, Abuse Prohibition states that it is the policy of this facility to screen and train employees to provide for the protection of residents and for the prevention, identification, investigation, and reporting of abuse, exploitation, neglect, mistreatment, and misappropriation of property.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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 report an allegation of verbal abuse to the state agency based on the regulatory timeframe for one resident (#30). The deficient practice could result in residents not being protected from abuse. Findings include: Resident #30 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, chronic kidney disease, encephalopathy, and hypertension. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a moderate cognitive impairment. A progress note dated January 30, 2024 revealed that residents were interviewed and notified appropriate agencies as per protocol. Resident #30 made an allegation of abuse to his therapist. The therapist alerted administration and this nurse at 3:10 p.m. and an investigation was started immediately. The responsible party, the resident's mother, was present when the resident was interviewed at 3:15 p.m. A psych consult was ordered for psychosocial well-being. A care plan dated January 30, 2023 revealed that resident #2 was involved in an allegation of abuse. Interventions included to order a psych consultation related to psychosocial well-being. A skin assessment dated [DATE] did not reveal any injuries. -Resident #2 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure, post traumatic stress disorder, and Rhabdomyolysis. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 5 indicating the resident had a severe cognitive impairment. The care plan dated January 6, 2023 did not reveal a plan for behaviors or PTSD. The progress note dated January 27, 2023 revealed that the resident had a verbal altercation with his roommate. The resident was moved to room [ROOM NUMBER]. The power of attorney is aware. A progress note dated January 30, 2023 revealed that the resident was involved in an allegation of abuse. Administration and this nurse were notified at 3:10 p.m. and an investigation was started immediately. The appropriate parties were notified and a psych consult was ordered. A care plan dated January 30, 2023 revealed that resident #2 was involved in an allegation of abuse. Interventions included to order a psych consultation related to psychosocial well-being. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress note dated January 30, 2023 revealed that the resident was moved to another room per his request. A skin assessment dated [DATE] did not reveal any injuries. Review of the 5-day investigation dated Review of the 5-day investigation dated February 3, 2023 revealed: -a physical therapy assistant (staff #21) informed the nurse that resident #30 was inquiring about the altercation that took place with him and his roommate. The staff informed the administrator on January 30, 2023 and started an investigation immediately by interviewing the two residents. - a certified nursing assistant (CNA/staff #9). Staff #9's statement revealed that on January 27, 2023, dietary staff (#62) reported to her that two residents were arguing and when she entered the room, resident #2 was close to resident #30's bed, and she heard resident #2 tell resident #30, if I ever get my hands on you, you're a dead man. The argument appeared to be over something on the TV. Staff #9 took resident #2 out of the room to avoid further arguing. -a statement from the dietary staff (#62), which stated that staff #62 worked on January 27, 2023 when resident #30 told staff #62 to come to his room because his roommate was threatening him. Staff #62 notified staff #9. -a psych evaluation for resident #30 dated February 3, 2023 where resident #30 stated that he was watching a TV program about a black man being assaulted by the police and resident #2 called him a n*****, n***** lover and said he would come over and kill him, beat him up. -a psych evaluation for resident #2 dated February 30, 2023 revealed that resident #2 stated that he was in bed and then that he did not remember going over to the resident 30's bed, threatening to kill him, or kicking the bed. Review of the online report revealed that the facility reported the allegation of verbal abuse that was reported by resident #30 to facility staff on January 27, 2024 and the facility reported the allegation to the state agency on January 30, 2024. An interview was conducted on November 19, 2024 with the Director of Nursing (DON/staff #1), who stated that she has received training on abuse which includes verbal abuse. She stated that verbal threats to harm with intimidation is a form of verbal abuse along with racial slurs, such as, n***** and n***** lover. Staff #1 reviewed the 5-day investigation, which included a statement from a certified nursing assistant (CNA/staff #9), and stated that the CNA's statement revealed that the incident occurred on January 27, 2023. An interview conducted on November 19, 2024 at 2:43 p.m. with the certified nursing assistant supervisor (CNA/staff #17), who stated that she has received training on abuse and verbal abuse includes cussing, name calling, derogatory comments, and threats. She stated that if a resident makes an allegation of abuse, she reports it immediately to the supervisor because they only have two hours to report it to the state agency. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Abuse Prohibition states that it is the policy of this facility to screen and train employees to provide for the protection of residents and for the prevention, identification, investigation, and reporting of abuse, exploitation, neglect, mistreatment, and misappropriation of property. The policy did not reveal the timeline in which allegations are to be reported to the state agency.