

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER The Gardens Rehab & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</p> <p>Based on observation, interviews, review of documentation, and review of facility policies, the facility failed to ensure that all allegations of abuse were reported to the state agency and other mandated entities within the required timeframe for one resident (#54). The deficient practice could lead to a failure of the facility to report allegations of abuse timely, and could lead to continued abuse for a resident.</p> <p>-Regarding Resident # 54:</p> <p>Resident # 54 was admitted to the facility on [DATE] and discharged [DATE], with diagnoses that included displaced transverse fracture of right patella, subsequent encounter for closed fracture with routine healing, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, altered mental status, unspecified, mild cognitive impairment of uncertain or unknown etiology.</p> <p>The Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 03, indicating the resident had severe cognitive impairment.</p> <p>A nursing progress note dated January 05, 2025, revealed that at approximately 5:53 PM, revealed the following note residents' spouse at the. Resident was in w/c in commons area and spouse pushed resident towards door of room. This writer was sitting at nurses station an overheard spouse talking to resident and stated, You fucking idiot, I can't take you home. You're so stupid, why can't you listen to me? You're fucking worthless. Nurse intervened and stepped between resident and spouse, and removed spouses' hands from w/c. Spouse continued to attempt to talk to resident stating, I can't take care of you, I'm not taking you home. This writer had another staff member stay with resident and escorted spouse out of facility and informed him that he isn't allowed to talk to resident in that way or tone. Administration updated per night supervisor</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Communication Note- with family/NOK/POA dated January 6, 2025 at 1:18 PM, Administrator in Training ((AIT/Staff # 12) revealed Assistant Administrator spoke with husband this morning regarding the interaction between resident's spouse and wife [NAME] yesterday afternoon. Resident's spouse told Assistant Administrator that his dog is very sick and having seizures. He was upset about the dogs' condition and then shared that information with resident #54 (he admitted to this being a mistake). Resident #54 then got very agitated and was wanting to leave. Resident's spouse said he got frustrated with everything going on and lost his temper. He was apologetic and said it won't happen again. He also told the Assistant Administrator that she had been calling him this morning wanting him to come in. Assistant Administrator and DON interviewed the resident. Resident doesn't recall the incident therefore resident did not seem negatively affected by the incident with her husband on 1/5/25. Resident stated she felt comfortable with her husband and doesn't feel uncomfortable with him at all.</p> <p>A Psychiatry/Mental Health note dated January 7, 2025 at 5:15 PM revealed that the provider met with Resident #54 for follow up to report of incident between spouse and resident and planned discharge. The note revealed that provider was informed by the facility that husband had cursed at resident #54 and told her that she was worthless. The report further revealed the resident's husband was escorted from the facility without incident. Resident #54 reported to the provider that the incident does not bother her. We always kiss and makeup.</p> <p>Review of the facility's Internal Investigation dated January 10, 2025 indicated the date of event was January 5, 2025. Further review of the facility investigation revealed the online report was submitted online to the state agency on January 7, 2025 at 2:30p with the notification of [NAME] Police Department Case Number 25-000571, APS, Physician, Family/Guardian, Ombudsman.</p> <p>An interview was conducted with the Licensed Practical Nurse (LPN/Staff # 17) on January 15, 2025 at 324 PM. Staff #17 stated she was sitting at the nurses station when she observed the spouse pushing the resident #54 in her wheelchair and he was leaned over as he pushed her talking to her loudly, calling the resident stupid, you're not listening to me, worthless, I can't take care of you, you can't go home, dropped a few F- bombs Staff #17 stated she walked over asked him to step back and told him I can't have you talk to her like that and he continued to try talking to her. Staff #17 stated she told the husband that he would have to leave and escorted him to the door and he left. She stated she contacted the DON. Staff #17 reported no changes observed with the resident and did not recall the incident with her husband did not seem phased by it. She reported no prior incidents that she is aware of and has always been pleasant with his wife during his daily visits.</p> <p>An interview was conducted with the Administrator (Staff #6) on January 15, 2025 at 3:58 PM. Staff #6 stated the incident occurred on Sunday, January 5, 2025 and was not reported to the state agencies until Tuesday, January 7, 2025. Staff #6 stated the AIT/Staff #12 was unaware that the incident was a reportable for verbal abuse. Staff #6 stated she had a conversation with staff #12 as why to the alleged abuse had not been reported to the state agencies. Staff # 6 stated he informed her that the spouse was gone, but did not ask any further questions or ask what was said to the resident. Staff # 6 stated it is her expectation that staff are able to identify abuse. Staff #6 stated staff #12 was provided with abuse education, training in identifying abuse and timely reporting. Staff #6 stated the risk s with not reporting in a timely manner are citations and fines for the facility.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON/Staff #13) on January 15, 2026 at 4:45 PM. The DON stated that she was made aware of the incident regarding resident #54 and her spouse and considered it to be verbal abuse. The DON stated any allegations for abuse are reported to the state agencies in within two hours. The DON stated the risks with not reporting in a timely manner are further complications for the people involved and the spouse could continue to speak to the resident that way. The DON stated Staff # 12 spoke to the spouse and the care plan was revised to provide supervised visits for resident #54 and her spouse. The DON stated it was her understanding that the husband had a lot of personal issues going on with the dog dying, concerned about his wife going home and his ability to care for her with her dementia. The DON stated the spouse was frustrated at the time of the incident and there had been no prior concerns with his visits.</p> <p>Review of the facility policy Abuse Reporting states all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and or injuries of unknown source (abuse) shall be promptly reported to local, state and federal; agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.</p> <p>2. Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property will be reported within two hours.</p>		