

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER The Lingenfelter Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1099 Sunrise 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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606</p> <p>Based on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to protect the rights of two residents (#520 and #525) to be free from abuse from each other. The deficient practice could result in further abuse of residents and appropriate action not taken.</p> <p>Findings include:</p> <p>-Resident #520 was admitted on [DATE] with diagnoses of vascular dementia with agitation/behavioral disturbance/psychotic disturbance/mood disturbance/anxiety, hemiplegia and hemiparesis following cerebrovascular disease.</p> <p>A care plan initiated on November 13, 2017 included the resident had confusion and poor decision making related to cognitive impairment, and limited mental function. Interventions included to determine limitations, explain procedures, and observe for signs of symptoms of disease.</p> <p>A verbal behavioral care plan initiated on November 13, 2017 revealed the resident makes loud verbal outbursts manifested by swearing and insults; and that, the resident will yell out/curse at others when uncomfortable in current situation. Interventions included to provide calm, non-rushed environment, check and assure physical comfort, and attempt to redirect.</p> <p>The physical behavior care plan initiated on November 13, 2017 included the resident exhibited negative physical behavior manifested by hitting, kicking, spitting, pinching or biting towards others. Interventions included to provide calm, non-rushed environment, provide individualized attention, and time, remove from situation if he begins to show signs of agitation in public, and remind calmly to refrain from physically acting out.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0 indicating that the resident had severe cognitive impairment. The MDS also included that the resident was negative for indicators of psychosis, physical behavioral symptoms directed towards others occurred daily during the assessment period; and, had verbal behavioral symptoms directed toward others that occurred 4-6 days during the assessment period.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A health status note dated February 24, 2024 revealed that there was a resident to resident incident involving the resident #520 that was witnessed. Per the documentation, both residents were separated, an investigation was done and reported to appropriate channels. The documentation also included interventions for resident such as notification of health care provider, power of attorney, case manager, and a psych evaluation.</p> <p>Review of the facility's incident report dated February 24, 2024 included that a certified nursing assistant (CNA) reported hearing the roommate (#525) of the resident yelling; and that, when the CNA entered the room, the CNA witnessed both residents in a scuffle. Per the documentation, resident #520 had a 2 cm (centimeter) x 1 cm abrasion on his left cheek; and that, the predisposing situation factor was that the resident dislikes roommate.</p> <p>-Resident #525 was readmitted on [DATE] with diagnoses of Alzheimer's disease, major depressive disorder, and dementia with agitation/behavioral disturbance/mood disturbance/anxiety.</p> <p>A significant change in status MDS assessment dated [DATE] revealed that the resident was severely impaired and never/rarely made decisions regarding tasks of daily life. The MDS also included that the resident continuously presented behaviors of inattention and disorganized thinking; exhibited physical behavior symptoms directed towards others which occurred daily during the assessment period; and, exhibited verbal behavioral symptoms directed towards others which occurred 4-6 days during the assessment period.</p> <p>A health status note dated February 24, 2024 documented that a CNA reported witnessing the end of the incident between resident #520 and #525.</p> <p>A physician order note dated February 24, 2024 revealed that resident #525 had a 2 cm x 1 cm abrasion on inner elbow and a 0.5 cm x 0.25 cm right 3rd knuckle abrasion.</p> <p>A social service note dated February 24, 2024 included that the resident representative was informed of room change for resident #525.</p> <p>Review of the Incident Report dated February 24, 2024 revealed that the resident was involved in an altercation with his roommate (#520); and that the incident was witnessed by the CNA. Per the documentation, resident #525 was unable to recall the event; and, resident #525 was assessed and was found to have a 2 cm x 1 cm abrasion on his left inner elbow. The documentation also included that #525 was the identified aggressor in the event. Interventions included psych consult and room change. The report also documented that predisposing situation factors as dislikes roommate.</p> <p>The facility report dated February 24, 2024 indicated that a CNA witnessed both residents (#520 and #525) struggling with each other in their shared room. Per the documentation, resident #525 was backward in his wheelchair against the bed of resident #520 on the side of the room for resident #520. According to the report, both residents were assessed for injuries; and, resident #520 had a small abrasion on his left cheekbone while resident #525 had a small abrasion with slight redness to his left inner elbow.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The final facility report dated February 28, 2024 revealed that resident #520 reported that resident #525 wheeled over to his side of the room; and that, resident #525 his wheelchair into the bed of resident #520. Further, resident #520 reported that he started yelling at resident #525 to get away from him; and that, resident #525 started hitting resident #520, who then began to hit back at the resident #525. The facility report included an interview with a certified nursing assistant (CNA/staff # 70) who reported witnessing the end of the resident to resident incident. The facility report also included a witness statement from a licensed practical nurse (LPN/staff #90) who reported that she saw resident #520 grasped the arm of resident #525 from behind while resident #525 pulled the arm of resident #520. According to the LPN's statement, resident #525 had an abrasion on his left arm with a nick to the inner elbow and a nick to his right third knuckle. Further review of the facility report revealed an interview conducted with a registered nurse (RN/staff #85) on February 24, 2024 at 11:05 a.m. who reported that resident #520 informed her that resident #525 was crazy and backed into his bed; and that, resident #520 yelled at him to get the f**k out of his room. Per the documentation, resident #520 reported that resident #525 went nuts and started hitting him and he hit resident #525 back.</p> <p>An undated behavioral care plan with a projected review date of May 24, 2024 revealed that the resident required frequent supervision and redirection from staff since he frequently enters other resident's personal space, make loud inappropriate comments, and had also been involved in a resident to resident altercation where he was the aggressor. Interventions included psychological evaluation with medication review as needed, staff that will care for resident are trained to care for cognitively impaired residents with behavioral issues who will practice resident specific techniques on how to approach the resident and provide cares, staff that will care for resident are trained in crisis intervention to diffuse situation in a manner that is safe for the resident and others.</p> <p>An interview with a restorative nursing assistant (RNA/staff #50) was conducted on March 27, 2024 at 10:01 a.m. The RNA stated that she was vaguely familiar with resident #525, only cared for him once, and, she had taken him to an eye doctor recently. The RNA said that she heard about an altercation but did not witness it or did not know who was involved. Regarding resident #525, the RNA stated that resident #525 was easy going, but gets really angry and screams; and that, when he was having a moment, resident #525 was difficult to redirect. However, the RNA said that staff could talk to resident #525 nicely and he would listen. Regarding resident #520, the RNA stated that she was familiar with resident #520 as she used to care for him; and that, resident #520 was a yeller and hits staff unprovoked. The RNA said that she was not sure why resident #520 does it; and that, resident #520 had dementia.</p> <p>A telephone interview the CNA (staff #70) who witnessed the altercation between resident #520 and #525 was conducted on March 27, 2024 at 10:27 a.m. The CNA declined the interview.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with a licensed practical nurse (LPN/staff # 90) conducted on March 27, 2027 at 10:31 a.m., the LPN stated that staff learn cues and end up learning the routine of residents they care for; and that, when a resident's behavior was out of the norm then it can become concerning or was an indicator that they are not having a good day or something was wrong. The LPN said that there was a resident to resident altercation that involved residents #520 and #525; and, the incident was not witnessed by anybody. The LPN said that resident #525 was with resident #520. Regarding resident #525, the LPN said that the resident #525 was triggered with loud voices and, does not normally make loud noises but does get loud and had to be told to be quiet but is easily redirectable. Regarding resident #520, the LPN said that the resident was verbally aggressive, can be physically aggressive, had one good arm that he likes to swing and staff had to move away and gracefully tell him not to do it. Regarding the incident, the LPN stated that one of the CNAs heard both residents yelling at each other and the CNA saw both residents entangled at each other. The LPN said that resident #520 had superficial scratches on his arm and chest; and, resident #525 had some scratches on his knuckles. Further, the LPN stated that resident #252 was the instigator of the incident since he can move around and therefore he was moved to another room after the incident.</p> <p>During an interview with the director of nursing (DON/staff # 85) conducted on March 27, 2024 at 1:12 p.m. the DON stated that following a resident to resident altercation, the expectation was that the incident is reported immediately, residents are separated immediately, investigated, interventions placed, and to move the resident to a unit where the residents will not have access to each other. The DON also said that if the residents cannot be prevented from accessing each other or further incidents involving that resident, then a referral is sent out so that the resident can be placed somewhere which was more appropriate for the resident in order to ensure the safety of that resident and other residents in the facility. The DON further stated that staff were provided training regarding abuse/neglect identification and reporting and she expects them to follow the protocol; and that, it was important for the resident's overall experience, quality of care, quality of life, and functionality.</p> <p>Review of the facility policy on Abuse Prevention Program dated June 1, 2020, revealed that it was their policy that their residents have the right to be free from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment and involuntary seclusion. Furthermore, the policy noted that the facility is committed to protecting residents from abuse by anyone to include other residents.</p>		