STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035262	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lingenfelter Center	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)
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** 49399 Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure two residents (#3 and #4) were provided adequate supervision to prevent resident abuse. The deficient practice could result in residents being at risk for abuse. Findings include: -Resident # 3 (alleged perpetrator) was admitted to the facility on [DATE] which include diagnoses of Hypertension, Diabetes Mellitus, Non-Alzheimer's Dementia, and Post Traumatic Stress Disorder (PTSD). Review of plan of care document titled, Standard Care Plans, dated October 29, 2024 revealed resident has confusion-poor decision making related to cognitive impairment, limited mental function and disease process. The interventions include reorient to situations as needed, anticipate needs, observe for signs and symptoms of disease, administer medications as ordered, observe for side effects and effectiveness, and note changes and notify medical doctor as needed. Review of plan of care document titled, Standard Care Plans, dated October 29, 2024 revealed resident has unsafe wandering. The interventions include monitor for any needed interventions such as alarms; monitor closely, 30 minutes safety checks as needed; notify for increased restlessness; anticipate needs such as thirst, hunger, and need to toilet; monitor for patterns and redirect to safe areas. Review of plan of care document titled, Standard Care Plans, dated October 29, 2024 revealed resident exhibits negative physical behavior manifested by hitting, kicking, spitting, pinching or biting towards others-strikes/hits/pinches/attempts to bite/scratch staff when they assist with activities of daily living or administer medications. The interventions include remove person from situation if begins to show signs of agitation in public place, remind calmly about the necessity to refrain from physical acting out. Review of plan of care document titled, Standard Care Plans, dated October 29, 2024 revealed resident require supervision and redirection from staff related to behaviors such as delusional thoughts, paranoia, verbal and physical aggression, accusatory statements, wandering, rejection of cares, agitation, and anxiousness. (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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(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	Review of plan of care document titled, Standard Care Plans, dated October 30, 2024 at 23:30, resident #3 was in a resident to resident altercation, resident #3 was the aggressor. The interventions included one on one conversation, reapproach, watching television, assess for injuries, and psych consult. Review of record, Medication Administration Record (MAR) dated October 31, 2024 at 01:35 revealed resident was administered Haldol and Ativan for signs and symptoms of clinical distress related to anxiety-pacing, unprovoked physical aggression-punching, short tempered and irritable, paranoia and delusions of believing resident is at home and others are intruders. Review of records from progress note titled physician's order note dated October 31, 2024 at 02:57 revealed resident-resident altercation, psych eval. Review of records from progress note titled Incident Note dated October 31, 2024 at 04:12 revealed 2 staff members heard curtains opening and several loud thuds, staff went down hall and entered room to find resident #3 pacing in circles in the middle of the room saying he did not approve of anybody else to stay in his house. Resident stated hit roommate and threw roommate out of bed. Residents separated. No injury noted to resident #3. Review of records from progress note titled Incident Follow Up dated October 31, 2024 at 10:24 revealed the provider was notified about a resident to resident incident on 10/30/2024 at 2330. Review of records from progress note titled Incident Follow Up dated October 31, 2024 at 10:32 revealed case manager informed about October 30, 2024 at 23:30 incident. Review of resident's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 5.0 indicating severely impaired, has difficulty focusing attention, has disorganized or incoherent thinking behavior, has physical behavioral symptoms directed towards others, and exhibited rejection of care and wandering behavior. Resident uses a walker for mobility. Resident is mostly independent with functional abilities which include walking 10 feet on uneven surfaces and bending/stoop from standing position to pick up a small object, such as a spoon, from the floor. Resident is taking Antipsychotic, Antianxiety, and Antidepressant medications. -Resident #4 (alleged victim) was admitted to the facility on [DATE] which include diagnoses of Heart Failure, Hypertension, and Non-Alzheimer's Dementia. A review of MDS admission assessment dated [DATE] revealed a BIMS score of 1.0 indicating severe impairment. Resident has difficulty focusing attention continuously. Resident exhibits physical and verbal behavioral symptoms directed towards others. Resident exhibits behaviors such as rejection of care and wandering. Resident mostly requires supervision or touching assistance with activities of daily living. Resident is taking Antipsychotic, Antidepressant, Anticoagulant, and Diuretic medications. A review of MDS quarterly assessment dated [DATE] revealed an entry date of November 3, 2023 and a BIMS score of 3.0 indicating severe impairment. Resident exhibits physical behavioral symptoms directed towards others, rejection of care and wandering. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of records titled Standard Care Plan dated November 3, 2023 revealed resident has confusion-poor decision making related to cognitive impairment, and disease process. Review of records titled Standard Care Plan dated November 15, 2023 revealed resident has impaired verbal communication manifested by difficult expressing thoughts. Review of records titled Standard Care Plan dated November 15, 2023 revealed resident has hearing loss, and vision impairment. Review of records titled Standard Care Plan dated November 15, 2023 revealed resident has verbal behaviors making loud verbal outburst, will yell out/curse at others when uncomfortable in current situation. Review of records from progress note Communication with Family dated October 31, 2024 at 01:48 revealed resident's family member was notified about an incident earlier and skin tear to right elbow and resident to move to another location within the facility. Review of records from progress note Physician's Order Note dated October 31, 2024 at 02:58 revealed regarding resident to resident altercation: 1.17 by 5 cm (centimeter) bruise to mid-back, LOTA (leave open to air). Review of records Incident Note in progress note dated October 31, 2024 at 04:19 revealed 2 staff members heard curtains opening and several loud thuds, staff went down hall and entered room to find resident #4 (alleged victim) on ground next to bed on his right side. Residents separated and resident #4 assessed for any injury with skin tear to right elbow and bruising to mid back. Resident #4 stated the roommate just started hitting and dragged him onto the floor. Resident #4 was assisted up onto bed for treatment to right elbow and to get dressed. Review of records titled Standard Care Plan dated October 31, 2024 revealed resident was in a resident to resident altercation. Resident #4 was not the aggressor. The intervention includes psych eval. Review of records, Clinical Census, dated October 31, 2024 revealed resident #4 was moved to another location within the facility. Review of records titled, N Adv-Skin Check-V 13, effective date 10/31/2024 04:22 revealed skin issues note skin tear to right elbow. Bruising to mid back. Review of records dated November 14, 2024 revealed resident #3 and resident #4 were roommates since October 29, 2024. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 13, 2024 at 2:40 pm with a certified nursing assistant (CNA)/resident care coordinator (RCC)/Staff #45. Staff #45 stated that her role consist of helping train CNAs to ensure they do everything for the resident. They are a CNA training facility, and after attending their training class, their students can work on their unit as helping hand while in training. Staff #45 stated that one of their halls is dedicated for male residents only. Regarding new resident admission, Staff #45 stated that they go with a nurse and start a new resident body survey to assess if they have any marks or wounds, and then the nurse documents their skin assessment and also takes the resident's vital signs. In addition, for new residents, their director of nursing (DON) will give them an admit packet to review any intervention relating to their new resident. For instance, do they need a wheelchair, turning or changing position schedule, are they fall risk, or are they coming with a wound. Staff #45 stated that when some of their residents have verbal outburst, they talk to them, they take them to their courtyard, to the bathroom, or they give them snack, provide activity to help deescalate the behavior or they help redirect them to calm them down. Staff #45 stated that they have monthly in-services to go over abuse, and different behaviors. Staff #45 stated that regarding resident #3, resident is [NAME] new to them and resident forgets due to sundown. And, in their all male resident hall, they have two CNAs and one nurse scheduled for day and night shifts. An interview was conducted on November 13, 2024 at 3:03 pm with a licensed practical nurse (LPN)/Quality Assurance Nurse (QA)/Staff #90. Staff #90 stated that for their new admitted resident, the floor nurse will do skin assessment, they go over the new orders, vaccines, and tuberculosis. The skin assessment is done to check for bruises, rashes, or open areas. Their newly admitted residents are on a 72-hours every 30 -minute safety check. The flowsheet for their safety check is in the resident's' room. Furthermore, regarding altercation between residents, they do investigation, their floor nurse immediately separate the residents, they assess for injuries and do evaluation. If they are roommates, one will stay in another room and will eventually be moved to another room or hall after family notification. On November 13, 2024 at 3:15 pm, resident #3 sleeping in bed and was unable to interview. An interview was conducted on November 13, 2024 at 4:26 pm with a CNA/Staff #123. Staff #123 stated that they are provided a care plan to review what their residents' needs are. They grab a care plan sheet every morning which has the following information: names of their residents, type of fluids, floor pad, 2-hour turning, and toileting, etc. The care plan sheet is printed out by their RCC. Staff #123 stated that regarding resident #4, the resident care plan is every 2-hour toileting and turning, resident has a bed pad alarm for fall risk precaution, resident can talk and walk, cooperative, and had an altercation with another resident in the other hall. Staff #123 stated that the other resident hit resident #4 and resident #4 was moved to their hall to be away from the resident who hit resident #4. Regarding resident to resident altercation their intervention is to separate them right away, and report to the nurse. An interview was conducted on November 13, 2024 at 4:39 pm with resident #4. Resident was sitting in the dining area, and observed a scab on their right outer elbow. Resident #4 stated that he scratched it and that no one had hurt her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 13, 2024 at 4:42 pm with a registered nurse (RN)/Staff #125. Staff #125 works in the mixed female and male hall. Staff #125 stated that when there is a resident to resident altercation, they separate them. Regarding resident care, their CNAs carry a pocket care plan, which is updated daily and they get it at the beginning of their shift. The RCC calls for any updates or changes regarding their residents so the RCC can make changes and update the pocket care plan. Regarding resident #4, Staff #125 stated that the resident was moved because there was concern about their roommate at the other hall, and the concern happened during night shift, and staff #125 is not familiar with the event. In addition, staff #125 stated that if they notice any tension from the residents, they separate them, they redirect them, and they provide reassurance. Some of their residents have an every 15-minute check typically due to a fall. They also check them on a regular basis when their passing medications, when walking in the hall, and they do a every 30-minute check start with their new admission for the first 48 hours. On November 14, 2024 at 09:06 am, resident #3 was unable to be interviewed. Resident sleeping. An interview was conducted on November 14, 2024 at 09:15 am with a CNA/Staff #60. Staff #60 stated that she heard about resident #3 incident, which the resident hit the other resident, and that happened in the middle of the night couple weeks ago. Regarding staffing, staff #60 stated that for 22 residents, there is an average of two CNAs and one nurse and sometimes they also have the helping hand staff scheduled. An interview was conducted on November 14, 2024 at 10:25 am with the administrator/Staff #31 and present during the interview was the DON/Staff #32. The administrator stated that regarding their abuse policy, their staff reports it directly to the administrator or the DON. Their staff separates the residents, they get their statement from staff and their residents, report the abuse incident, and finish their investigation. The administrator stated that they were informed about the potential resident to resident altercation, their investigation started, their staff were in a one on one with the resident, they performed skin assessment, one resident was moved to another unit, they informed their psych provider, ombudsman, the department, their physician, and their case manager. The administrator stated that regarding resident #3, they did not find any apparent injury and resident #3 made a statement that someone was in their house. And, regarding resident #4, the administrator stated that their nurse indicated that the resident was found on the floor, had a skin tear on the elbow, and an abrasion on their back. The administrator added that resident #4 regularly sit in a recliner, and a week or 2 prior to the incident, resident #4 had slid off the bed in regards to potential abrasion on his back. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 15, 2024 at 09:49 am, LPN/Staff #129 returned a call for an interview. Staff #129 stated that they work 12-hours night shift and they remembered the incident with resident #3. Staff #129 stated that around 11:30 pm at night, they were up in the desk with one CNA and the other CNA was out on lunch, they were making their vital signs paper for the next day, and staff #129 was not sure what the other CNA was doing, and staff #129 heard a loud noise, curtains divider had been closed previous and heard the sound of the curtain opening so they went down the hallway. They found resident #3 pacing in the room, and the other resident/roommate was on the ground. Resident #3 was talking to themselves and the other resident just on the ground. Resident #3 was assessed with no injury and the other resident 's elbow had a big new skin tear on their right forearm/elbow that was bleeding like it was fresh. They separated the residents, they called the on-call supervisor, they took resident #3 to the dining room and they treated the roommate's skin tear by cleansing their skin tear and assessing for any other injuries. Regarding their training, Staff #129 stated that they have monthly in services, they have the crisis to care training bi yearly or yearly, and a training hand and hand for de-escalation and redirection. Review of facility's policy titled, Abuse Prevention Program, has no issued date and no review or revised date revealed it is the policy of this facility for our residents to have the right to be free from abuse. Review of facility's policy titled, Resident Rights, has no issued date and no review or revised date revealed the facility policy is will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure two residents (#3 and #4) were provided adequate supervision to prevent resident abuse. The deficient practice could result in residents being at risk for abuse. Findings include: -Resident # 3 (alleged perpetrator) was admitted to the facility on [DATE] which include diagnoses of Hypertension, Diabetes Mellitus, Non-Alzheimer's Dementia, and Post Traumatic Stress Disorder (PTSD). Review of plan of care document titled, Standard Care Plans, dated October 29, 2024 revealed resident has confusion-poor decision making related to cognitive impairment, limited mental function and disease process. The interventions include reorient to situations as needed, anticipate needs, observe for signs and symptoms of disease, administer medications as ordered, observe for side effects and effectiveness, and note changes and notify medical doctor as needed. Review of plan of care document titled, Standard Care Plans, dated October 29, 2024 revealed resident has unsafe wandering. The interventions include monitor for any needed interventions such as alarms; monitor closely, 30 minutes safety checks as needed; notify for increased restlessness; anticipate needs such as thirst, hunger, and need to toilet; monitor for patterns and redirect to safe areas. Review of plan of care document titled, Standard Care Plans, dated October 29, 2024 revealed resident exhibits negative physical behavior manifested by hitting, kicking, spitting, pinching or biting towards others-strikes/hits/pinches/attempts to bite/scratch staff when they assist with activities of daily living or administer medications. The interventions include remove person from situation if begins to show signs of agitation in public place, remind calmly about the necessity to refrain from physical acting out. Review of plan of care document titled, Standard Care Plans, dated October 29, 2024 revealed resident require supervision and redirection from staff related to behaviors such as delusional thoughts, paranoia, verbal and physical aggression, accusatory statements, wandering, rejection of cares, agitation, and anxiousness. Review of plan of care document titled, Standard Care Plans, dated October 30, 2024 at 23:30, resident #3 was in a resident to resident altercation, resident #3 was the aggressor. The interventions included one on one conversation, reapproach, watching television, assess for injuries, and psych consult. Review of record, Medication Administration Record (MAR) dated October 31, 2024 at 01:35 revealed resident was administered Haldol and Ativan for signs and symptoms of clinical distress related to anxiety-pacing, unprovoked physical aggression-punching, short tempered and irritable, paranoia and delusions of believing resident is at home and others are intruders. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of records from progress note titled physician's order note dated October 31, 2024 at 02:57 revealed resident-resident altercation, psych eval. Review of records from progress note titled Incident Note dated October 31, 2024 at 04:12 revealed 2 staff members heard curtains opening and several loud thuds, staff went down hall and entered room to find resident #3 pacing in circles in the middle of the room saying he did not approve of anybody else to stay in his house. Resident stated hit roommate and threw roommate out of bed. Residents separated. No injury noted to resident #3. Review of records from progress note titled Incident Follow Up dated October 31, 2024 at 10:24 revealed the provider was notified about a resident to resident incident on 10/30/2024 at 2330. Review of records from progress note titled Incident Follow Up dated October 31, 2024 at 10:32 revealed case manager informed about October 30, 2024 at 23:30 incident. Review of resident's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 5.0 indicating severely impaired, has difficulty focusing attention, has disorganized or incoherent thinking behavior, has physical behavioral symptoms directed towards others, and exhibited rejection of care and wandering behavior. Resident uses a walker for mobility. Resident is mostly independent with functional abilities which include walking 10 feet on uneven surfaces and bending/stoop from standing position to pick up a small object, such as a spoon, from the floor. Resident is taking Antipsychotic, Antianxiety, and Antidepressant medications. -Resident #4 (alleged victim) was admitted to the facility on [DATE] which include diagnoses of Heart Failure, Hypertension, and Non-Alzheimer's Dementia. A review of MDS admission assessment dated [DATE] revealed a BIMS score of 1.0 indicating severe impairment. Resident has difficulty focusing attention continuously. Resident exhibits physical and verbal behavioral symptoms directed towards others. Resident exhibits behaviors such as rejection of care and wandering. Resident mostly requires supervision or touching assistance with activities of daily living. Resident is taking Antipsychotic, Antidepressant, Anticoagulant, and Diuretic medications. A review of MDS quarterly assessment dated [DATE] revealed an entry date of November 3, 2023 and a BIMS score of 3.0 indicating severe impairment. Resident exhibits physical behavioral symptoms directed towards others, rejection of care and wandering. Review of records titled Standard Care Plan dated November 3, 2023 revealed resident has confusion-poor decision making related to cognitive impairment, and disease process. Review of records titled Standard Care Plan dated November 15, 2023 revealed resident has impaired verbal communication manifested by difficult expressing thoughts. Review of records titled Standard Care Plan dated November 15, 2023 revealed resident has hearing loss, and vision impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of records titled Standard Care Plan dated November 15, 2023 revealed resident has verbal behaviors making loud verbal outburst, will yell out/curse at others when uncomfortable in current situation. Review of records from progress note Communication with Family dated October 31, 2024 at 01:48 revealed resident's family member was notified about an incident earlier and skin tear to right elbow and resident to move to another location within the facility. Review of records from progress note Physician's Order Note dated October 31, 2024 at 02:58 revealed regarding resident to resident altercation: 1.17 by 5 cm (centimeter) bruise to mid-back, LOTA (leave open to air). Review of records Incident Note in progress note dated October 31, 2024 at 04:19 revealed 2 staff members heard curtains opening and several loud thuds, staff went down hall and entered room to find resident #4 (alleged victim) on ground next to bed on his right side. Residents separated and resident #4 assessed for any injury with skin tear to right elbow and bruising to mid back. Resident #4 stated the roommate just started hitting and dragged him onto the floor. Resident #4 was assisted up onto bed for treatment to right elbow and to get dressed. Review of records titled Standard Care Plan dated October 31, 2024 revealed resident was in a resident to resident altercation. Resident #4 was not the aggressor. The intervention includes psych eval. Review of records, Clinical Census, dated October 31, 2024 revealed resident #4 was moved to another location within the facility. Review of records titled, N Adv-Skin Check-V 13, effective date 10/31/2024 04:22 revealed skin issues note skin tear to right elbow. Bruising to mid back. Review of records dated November 14, 2024 revealed resident #3 and resident #4 were roommates since October 29, 2024. An interview was conducted on November 13, 2024 at 2:40 pm with a certified nursing assistant (CNA)/resident care coordinator (RCC)/Staff #45. Staff #45 stated that her role consist of helping train CNAs to ensure they do everything for the resident. They are a CNA training facility, and after attending their training class, their students can work on their unit as helping hand while in training. Staff #45 stated that one of their halls is dedicated for male residents only. Regarding new resident admission, Staff #45 stated that they go with a nurse and start a new resident body survey to assess if they have any marks or wounds, and then the nurse documents their skin assessment and also takes the resident's vital signs. In addition, for new residents, their director of nursing (DON) will give them an admit packet to review any intervention relating to their new resident. For instance, do they need a wheelchair, turning or changing position schedule, are they fall risk, or are they coming with a wound. Staff #45 stated that when some of their residents have verbal outburst, they talk to them, they take them to their courtyard, to the bathroom, or they give them snack, provide activity to help deescalate the behavior or they help redirect them to calm them down. Staff #45 stated that they have monthly in-services to go over abuse, and different behaviors. Staff #45 stated that regarding resident #3, resident is [NAME] new to them and resident forgets due to sundown. And, in their all male resident hall, they have two CNAs and one nurse scheduled for day and night shifts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 13, 2024 at 3:03 pm with a licensed practical nurse (LPN)/Quality Assurance Nurse (QA)/Staff #90. Staff #90 stated that for their new admitted resident, the floor nurse will do skin assessment, they go over the new orders, vaccines, and tuberculosis. The skin assessment is done to check for bruises, rashes, or open areas. Their newly admitted residents are on a 72-hours every 30 -minute safety check. The flowsheet for their safety check is in the resident's' room. Furthermore, regarding altercation between residents, they do investigation, their floor nurse immediately separate the residents, they assess for injuries and do evaluation. If they are roommates, one will stay in another room and will eventually be moved to another room or hall after family notification. On November 13, 2024 at 3:15 pm, resident #3 sleeping in bed and was unable to interview. An interview was conducted on November 13, 2024 at 4:26 pm with a CNA/Staff #123. Staff #123 stated that they are provided a care plan to review what their residents' needs are. They grab a care plan sheet every morning which has the following information: names of their residents, type of fluids, floor pad, 2-hour turning, and toileting, etc. The care plan sheet is printed out by their RCC. Staff #123 stated that regarding resident #4, the resident care plan is every 2-hour toileting and turning, resident has a bed pad alarm for fall risk precaution, resident can talk and walk, cooperative, and had an altercation with another resident in the other hall. Staff #123 stated that the other resident hit resident #4 and resident #4 was moved to their hall to be away from the resident who hit resident #4. Regarding resident to resident altercation their intervention is to separate them right away, and report to the nurse. An interview was conducted on November 13, 2024 at 4:39 pm with resident #4. Resident was sitting in the dining area, and observed a scab on their right outer elbow. Resident #4 stated that he scratched it and that no one had hurt her. An interview was conducted on November 13, 2024 at 4:42 pm with a registered nurse (RN)/Staff #125. Staff #125 works in the mixed female and male hall. Staff #125 stated that when there is a resident to resident altercation, they separate them. Regarding resident care, their CNAs carry a pocket care plan, which is updated daily and they get it at the beginning of their shift. The RCC calls for any updates or changes regarding their residents so the RCC can make changes and update the pocket care plan. Regarding resident #4, Staff #125 stated that the resident was moved because there was concern about their roommate at the other hall, and the concern happened during night shift, and staff #125 is not familiar with the event. In addition, staff #125 stated that if they notice any tension from the residents, they separate them, they redirect them, and they provide reassurance. Some of their residents have an every 15-minute check typically due to a fall. They also check them on a regular basis when their passing medications, when walking in the hall, and they do a every 30-minute check start with their new admission for the first 48 hours. On November 14, 2024 at 09:06 am, resident #3 was unable to be interviewed. Resident sleeping. An interview was conducted on November 14, 2024 at 09:15 am with a CNA/Staff #60. Staff #60 stated that she heard about resident #3 incident, which the resident hit the other resident, and that happened in the middle of the night couple weeks ago. Regarding staffing, staff #60 stated that for 22 residents, there is an average of two CNAs and one nurse and sometimes they also have the helping hand staff scheduled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035262	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lingenfelter Center	1099 Sunrise Avenue Kingman, AZ 86401

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 14, 2024 at 10:25 am with the administrator/Staff #31 and present during the interview was the DON/Staff #32. The administrator stated that regarding their abuse policy, their staff reports it directly to the administrator or the DON. Their staff separates the residents, they get their statement from staff and their residents, report the abuse incident, and finish their investigation. The administrator stated that they were informed about the potential resident to resident altercation, their investigation started, their staff were in a one on one with the resident, they performed skin assessment, one resident was moved to another unit, they informed their psych provider, ombudsman, the department, their physician, and their case manager. The administrator stated that regarding resident #3, they did not find any apparent injury and resident #3 made a statement that someone was in their house. And, regarding resident #4, the administrator stated that their nurse indicated that the resident was found on the floor, had a skin tear on the elbow, and an abrasion on their back. The administrator added that resident #4 regularly sit in a recliner, and a week or 2 prior to the incident, resident #4 had slid off the bed in regards to potential abrasion on his back. On November 15, 2024 at 09:49 am, LPN/Staff #129 returned a call for an interview. Staff #129 stated that they work 12-hours night shift and they remembered the incident with resident #3. Staff #129 stated that around 11:30 pm at night, they were up in the desk with one CNA and the other CNA was out on lunch, they were making their vital signs paper for the next day, and staff #129 was not sure what the other CNA was doing, and staff #129 heard a loud noise, curtains divider had been closed previous and heard the sound of the curtain opening so they went down the hallway. They found resident #3 pacing in the room, and the other resident/roommate was on the ground. Resident #3 was talking to themselves and the other resident just on the ground. Resident #3 was assessed with no injury and the other resident 's elbow had a big new skin tear on their right forearm/elbow that was bleeding like it was fresh. They separated the residents, they called the on-call supervisor, they took resident #3 to the dining room and they treated the roommate's skin tear by cleansing their skin tear and assessing for any other injuries. Regarding their training, Staff #129 stated that they have monthly in services, they have the crisis to care training bi yearly or yearly, and a training hand and hand for de-escalation and redirection. Review of facility's policy titled, Abuse Prevention Program, has no issued date and no review or revised date revealed it is the policy of this facility for our residents to have the right to be free from abuse. Review of facility's policy titled, Resident Rights, has no issued date and no review or revised date revealed the facility policy is will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.