

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 05/15/2025
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** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that one resident (#4) was free from physical abuse by another resident (#2). The deficient practice could result in residents suffering from injuries.</p> <p>Findings include:</p> <p>Regarding resident #4</p> <p>-Resident #4 was admitted on [DATE] with diagnoses that included unspecified dementia, rash and other nonspecific skin eruption, insomnia, hypothyroidism, unspecified complications of genitourinary prosthetic device and bradycardia.</p> <p>An annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 12 indicating the resident had moderate cognitive impairment.</p> <p>The resident ' s MDS also revealed physical behavioral symptoms directed towards others that included, but was not limited to, hitting, kicking and pushing.</p> <p>Review of the resident ' s behavioral care plan dated September 12, 2024 revealed a problem of the resident being protective of his personal space.</p> <p>Review of resident #4 ' s standard care plan dated December 23, 2024 revealed a problem of the resident exhibiting negative physical behaviors as evidenced by hitting, kicking, spitting, pinching or biting towards others.</p> <p>A progress note dated May 5, 2025 at 16:24 by a Registered Nurse (RN/Staff #112) revealed that the resident had poor awareness of proximity to staff and other residents. The note further stated that the resident would get ' very close ' to staff and other residents and needs frequent redirection.</p> <p>A progress note dated May 11, 2025 at 11:50 by RN/Staff #112 revealed that resident #4 was in the dining room and entered another resident ' s (resident #2) personal space. Resident #2 balled up his right fist and swung towards resident #4 and grazed his left cheek. The residents were separated and redirected from one another.</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
---	-------	-----------

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 05/15/2025
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>Regarding resident #2</p> <p>Resident #2 was admitted on [DATE] with diagnoses that included unspecified dementia, seborrheic dermatitis, vascular dementia moderate with psychotic disturbance, anxiety disorder, unspecified mood disorder and unspecified psychosis.</p> <p>A quarterly MDS assessment dated [DATE] revealed that the resident had a BIMS score of 00 indicating the resident had severe cognitive impairment. Further review revealed the resident had inattention and disorganized thinking that was continuously present.</p> <p>The resident ' s MDS also revealed physical behavioral symptoms directed towards others that included, but was not limited to, hitting, kicking and pushing.</p> <p>Review of resident #4 ' s standard care plan dated November 23, 2022 revealed a problem of the resident exhibiting negative physical behaviors as evidenced by hitting, kicking, spitting, pinching or biting towards others. As well as verbal outbursts during meals and activities that disturbs others.</p> <p>Review of the resident ' s behavioral care plan dated December 5, 2024 revealed a problem of the resident needing supervision and redirection due to his wandering/pacing and territorial to space.</p> <p>A progress note dated May 11, 2025 at 11:50 by RN/Staff #112 revealed that resident #2 entered another resident ' s (resident #4) personal space. Resident #2 balled up his right fist and swung towards resident #4 and grazed his left cheek. The residents were separated and redirected from one another.</p> <p>An interview with a Certified Nursing Assistant (CNA/staff #64) was conducted on May 15, 2025 at 10:02 a. m. Staff #64 stated she was the one who intervened after the physical altercation. The CNA detailed that she did not see what transpired prior to the altercation but saw resident #2 attempting to take away a bedside table from resident #4. She further stated that she saw resident #2 punch resident #4 in the face and intervened with the nurse to avoid resident #4 from striking resident #2 in retaliation. The CNA recounted that the resident did make contact with the other resident and as a result resident #4 had a red mark on his face. Staff #64 stated that there were no prior altercations between the two residents. The CNA also stated that the facility has training and education for staff on abuse. Finally, the CNA stated that the facility process is to report any alleged abuse immediately which she did and reported to the nurse who then reported it to the Administrator and Director of Nursing (DON).</p> <p>(continued on next page)</p>

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 05/15/2025
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>An interview with a RN (staff #112) was conducted on May 15, 2025 at 10:10 a.m. Staff #112 stated that the two residents were very territorial, specifically resident #2 who is path driven and does things in a certain manner. The RN further detailed that Sunday morning the two gentleman ' s paths crossed and the two residents were on either side of a bedside table arguing over its placement. The RN stated that resident #2 balled up his right fist and hit resident #4 ' s left cheek. In return resident #4 balled up his fist as well but staff intervened before another punch was thrown. Staff #112 stated that she noticed slight pinkness to resident #4 ' s cheek where contact was made and there were no further injuries noted. The RN stated that she assessed resident #2 ' s right hand and his mental status and notified the altercation to the DON. She further stated that she documented the altercation in the facility ' s electronic health record. The RN stated that after the altercation the residents returned to their normal demeanors and there were no prior aggressive behaviors between the two. The RN stated that facility policy is to immediately separate the residents, assess those involved and report it as soon as possible. Staff #64 concluded by stating that the facility provides training on abuse via an annual inservice, at monthly all staff meetings and an online educational platform.</p> <p>An interview was conducted on May 15, 2025 at 11:04 a.m., with the Administrator (staff #73) who serves as the facilities investigator. The administrator stated that she was notified of the alleged abuse by the DON who was notified by the nurse on duty. Staff #73 detailed what was reported to her , she stated that resident #2 had been wandering in the dining area and resident #4 had come out of his room to the dining room. She further stated that resident #4 sat in a recliner that was in resident #2 ' s path that he had been pacing. The administrator stated that resident #4 grabbed a beside table and when he turned he was in resident #2 ' s path. Resident #2 then grabbed onto the table and the two were moving it back and forth between one another. Staff #73 then stated that it was reported to her that resident #2 then grazed resident #4 ' s face with a closed fist. The administrator stated that staff reported there was a connection. The administrator stated that resident #4 was immediately separated and transferred to another unit and there was an order for 1:1 monitoring with resident #2 in addition to updating both resident ' s care plans. The administrator stated that she notified all appropriate parties including the local police department during the course of her investigation.</p> <p>Review of facility policy signed into effect on June 1, 2020 by the administrator titled, Abuse Prevention Program, states that the facility is committed to protecting its residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to its residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual.</p>		