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	04/08/2026

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** Based on clinical record review, facility documentation, and staff interviews, the facility failed to protect the rights for two of three sampled residents (#3, #5) to be free from physical abuse by another resident. The deficient practice could lead to additional resident-to-resident altercations, creating an unsafe environment. The sample was 3. The universe was 3.Findings include:A facility-reported 5-day investigation, submitted to the State Agency on April 3, 2026, revealed that a resident-to-resident altercation occurred on March 31, 2026, at approximately 7:11 PM, involving Resident #3 and Resident #5. The report included an interview conducted with Resident #3 on March 31, 2026, at 7:26 PM revealed that he had been pushed from behind, told Resident #5 to leave him alone, and was then struck in the face. The report included an interview with the alleged aggressor, Resident #5 on March 31, 2026, at 7:32 PM which revealed that Resident #3 approached him, and Resident #5 pushed him and struck him in the neck to push him back. The report also included a signed witness statement dated March 31, 2026, by Certified Nursing Assistant (CNA/Staff #33) revealing that the CNA observed Resident #5 standing in front of Resident #3 with hands raised. Resident #3 was observed with blood on the bridge of his nose, and Resident #5 was wiping blood from his hand onto his pants. The CNA reported that Resident #3 stated Resident #5 hit him in the nose. The also report included that the CNA was able to get in between the two residents to separate them. A skin assessment dated [DATE], revealed that Resident #3 sustained two abrasions to the bridge of the nose, measuring 0.25 cm. Resident #5 had no injuries. A psychiatric consultation dated April 1, 2026 included in the report, revealed that Resident #5 was identified as the aggressor and had punched his peer. The consultation for Resident #3 revealed the incident was described as somewhat traumatic.Regarding Resident #3:Resident #3 was admitted on [DATE], with diagnoses that included dementia, with behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, agitation; and Alzheimer's disease.An annual MDS (minimum data set) assessment dated [DATE], revealed a BIMS (brief interview of mental status) score of 00, indicating severe cognitive impairment. The assessment also revealed that the resident exhibited physical and verbal behavioral symptoms directed towards others, rejection of care and wandering behaviors, 1 to 3 days of the assessment reference date.A Neurologic Focused Evaluation dated March 11, 2026, revealed that the resident has disorganized thinking, requires cues and is oriented to person and place. The evaluation included that the resident has mild impairment with some confusion, is coherent, speech is clear and usually makes self-understood, and usually understands others.A Neurologic Focused Evaluation, dated March 14, 2026 revealed the resident was experiencing signs of short-term memory loss, with severe cognitive impairment, and no unwanted behaviors witnessed.An incident follow-up note dated March 16, 2026 revealed that the resident continued to propel self around hall.Behavior progress notes dated March 23, 28, and 29, 2026, documented anxiety, delusions, and escalating behaviors. There was no evidence in the clinical record that the provider was notified of these behaviors.A care plan initiated on March 31, 2026, revealed that Resident #3 was reported to have been involved in a resident-to-resident altercation. Interventions included a psych consult, nursing staff to monitor and assess for (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035262	A. Building B. Wing	04/08/2026

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	signs/symptoms of a decline in psychosocial well-being.A skin assessment dated [DATE], revealed that Resident #3 received two small wounds, measured at 0.25 cm each.An incident note dated March 31, 2026, revealed that a CNA (certified nursing assistant) came around the corner and saw two residents facing each other, and observed Resident #3's nose bleeding.A psychiatric consultation dated April 1, 2026, revealed Resident #3 had been seen following a Resident-to-Resident altercation, where he stated it was somewhat of a traumatic experience. The consultation also revealed that Resident #3 was observed with a skin tear to the nose. -Regarding Resident #5:Resident #5 was admitted on [DATE], with diagnoses that included Alzheimer's disease, dementia with mood disturbance, psychotic disturbance, other behavioral disturbance, and post-traumatic stress disorderAn MDS assessment dated [DATE], revealed a BIMS score of 00, which indicated severe cognitive impairment. The assessment also revealed that the resident exhibited physical and verbal behavioral symptoms directed towards others, and rejection of care, 1 to 3 days of the 7 before the completion of the assessment reference date. The assessment also revealed that Resident #5 exhibited behavioral symptoms not directed towards others, and wandering behaviors 4 to 6 days before the assessment reference date. A behavior progress note dated March 20, 2026 revealed that the resident had repetitive behaviors, was restless, and began to get impatient with attempts to redirect.Behavior progress note dated March 22, 2026 and March 23, 2026, documented that the resident was exhibiting anxiety, delusional statements, pacing, was making repetitive statements to staff, and that redirection had been effective for a short period of time. There was no evidence the provider was notified of the behaviors.A behavior progress note dated March 26, 2026 and March 30, 2026, revealed that the resident wanders the hall, and was easily directed by staff.A care plan initiated on March 31, 2026, revealed that Resident #5 was reported to have been involved in a resident-to-resident altercation. Interventions included a psych consult, and nursing staff to monitor/assess for signs/symptoms of a decline in psychosocial well-being.A skin assessment dated [DATE], revealed that Resident #5 had no injuries.A behavior note dated March 31, 2026, at 4:10 PM (approximately 3 hours prior to the incident), revealed the resident was combative with staff, including pushing, hitting, and pinching, and was not easily redirected. However, there was no evidence that the provider was notified regarding the behaviors.An incident progress note on March 31, 2026, at 7:10 PM, revealed that a CNA came around the corner and saw two residents facing each other, and observed the other resident's nose bleeding.A psychiatric consultation dated April 1, 2026, revealed Resident #5 had been seen following a Resident-to-Resident altercation in which he was the aggressor. The consultation also revealed that Resident #5 was walking down the hall when he encountered a peer, who turned around to tell Resident #5 to stop, and Resident #5 punched the peer in the nose.A phone interview was attempted with the CNA who separated the two residents (Staff #33) on April 8, 2026, at 1:13 PM; however, it was unsuccessful. A phone interview was attempted with the CNA who was assigned to the unit (Staff #12) on April 8, 2026, at 1:16 PM; however, it was unsuccessful, with no return response. A phone interview was attempted with the LPN (licensed practical nurse) who was assigned to the unit (Staff #43) on April 8, 2026, at 1:18 PM; however, it was unsuccessful. An interview was conducted on April 8, 2026, at 1:55 PM with a CNA (Staff #3), who stated that the facility provided abuse training and that incidents of abuse, such as punching or hitting, would need to be reported immediately to the nurse of the unit, the DON (director of nursing), and the Administrator. The CNA stated that they were made aware of the incident between Resident #3 and #5 due to the room change, but had not been on shift during the incident. An interview was conducted on April 8, 2026, at 2:06 PM, with an RN (registered nurse/Staff #52) who stated that the facility provided abuse training and that incidents of abuse, such as punching or hitting, would need to be reported immediately to her supervisor, the DON, and the Administrator. The RN stated that she did not witness the incident, but was informed of what transpired between Resident #3 and Resident #5. She further stated that should a resident-to-resident altercation occur on her shift, she would ensure the residents are safe and separated, have staff sit with both residents individually, while (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	04/08/2026

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	notifications to the DON and the administrator are made. Then she would assess the residents for any injuries, treat any injuries, assist with the investigation by providing statements, and then assist with moving the residents to separate units to prevent further contact. A joint interview was conducted on April 8, 2026, at 2:21 PM, with the DON (Staff #73) and the Administrator (Staff #62). The DON stated that staff receive abuse training on the different types of abuse, who to report it to, and anticipating behaviors of residents to prevent altercations. The DON stated that she was notified regarding the resident-to-resident altercation between Resident #3 and #5, and that there had not been any witnesses. The DON stated that Resident #3 was observed with an abrasion on the bridge of his nose and stated that he had been ?sucker punched.' and that Resident #5 was not observed with any injuries. The DON stated that review of the video footage revealed that Residents #3 and Resident #5 had a tuffle, described as an interaction in the hallway where Resident #5 had his hands up, but had been uncertain if there was physical contact and due to not having a clear view of the altercation and the inconsistencies of additional interviews with the residents, the facility was unable to verify or refute that abuse occurred. The video footage was still available and was reviewed with both the DON and the Administrator, and the video was unclear related to physical contact between the residents; however, the wheelchair of Resident #3 was observed rocking back and forth in what appeared to be an uncontrolled fashion, but the video contained no evidence that physical contact was made to the face due to the back of Resident #5 facing the camera. A facility policy titled, Resident Rights Policies and Procedures, last edited in November of 2021, defined resident abuse as the willful infliction of injury; It also included abuse types such as verbal abuse, sexual abuse, physical abuse. The policy defined physical abuse as the intentional infliction of physical pain or injury to the resident, or the resident is inappropriately restrained.