

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
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)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and review of facility documentation and policy, the facility failed to ensure that privacy was maintained during medication administration for 3 residents (#203, #200, and #206) out of 11 sampled residents. The universe was 87. This deficient practice could result in unauthorized access to residents' private medical records. Findings include:-Resident #203Resident #203 was admitted on [DATE] with diagnosis including vascular dementia with anxiety, type 2 diabetes mellitus, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive impairment. An observation conducted of medication administration with Registered Nurse (RN, Staff #70) on July 8, 2026, at 11:10 a.m During medication administration the RN prepared medications for Resident #203. The RN stepped away from the medication cart and went into medication storage room; however, the computer screen was not closed or locked, and displayed Resident #203's name, date of birth and medications. Staff #70 came back to screen at approximately 11:14 a.m. and utilized the computer, then minimized the screen and went to check blood sugar for Resident #203 in his room.-Resident #200Resident #200 was admitted on [DATE], with diagnosis including unspecified dementia with anxiety, post-traumatic stress disorder, type 2 diabetes mellitus, and sleep apnea. A review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 01, indicating severe cognitive impairment. An observation was made on July 8, 2026, at 1:29 p.m., during medication administration with Registered Nurse (RN, Staff #70) who prepared medications for Resident #200. Staff #70 then stepped away from the medication cart at approximately 1:34 p.m., and went to Resident #200 in the dining area to administer his medications; however, the computer screen was not closed or locked, and displayed Resident #200's name, date of birth and medications. Resident #200 refused to take his medications and at approximately 1:35 p.m., Staff #70 then went to wash her hands with the computer screen still open and which displayed Resident #200 medical information.-Resident #206Resident #206 was admitted on [DATE], with diagnosis including Alzheimer's disease, acute kidney failure, seizure, dementia, hypertension, and type 2 diabetes. A review of the MDS assessment dated [DATE], revealed a BIMS score of 00, indicating severe cognitive impairment. An observation was made on July 8, 2026, at 1:36 p.m., with Registered Nurse (RN, Staff #70) who prepared medications for Resident #206. Staff #70 was observed crushing the Resident's medications and mixing in chocolate pudding. At approximately 1:38 p.m., Staff #70 administered the medications to Resident #206 in the dining area; however, the computer screen was not closed or locked, and displayed Resident #206's name, date of birth and medications. An interview was conducted on July 8, 2026, at 3:04 p.m., with the RN (Staff #70), who stated that she is a PRN (as needed) nurse and worked in the facility for a year. The RN stated that she provided medication administration and wound treatment to residents. The RN further stated that the facility expectation (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
--	-------	-----------

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 07/09/2026
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)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during medication administration, was to ensure that computer screens were locked, when away from the medication cart, because other residents could read patient's personal information, demography and medication documentation. The RN stated that she recalled leaving the computer screen on once or twice on July 8, 2026, for residents #200 and #206 during the medication administration. The RN further stated that risk if the computer screen was left unlocked would be a HIPAA (Health Insurance Portability and Accountability Act) violation and other people could read the patient's personal information. An interview was conducted on July 9, 2026, at 8:26 a.m., with a Licensed Practical Nurse (LPN) Staff #21, who stated that she provides wound treatment and medication administration to residents. The LPN stated that during medication administration, she would verify the resident's order, prepare medication, lock the computer screen and medication cart, and then go to the resident's room to administer the medications. The LPN stated that the facility had taken measures to protect resident information by instructing staff to close the computer screen and cover all documents before stepping away from the computer during the medication administration. The LPN further stated that the risk if a computer screen was left unlocked, would be a HIPAA violation and other residents would be able to read patient's medical information, demography, and code status. An interview was conducted on July 9, 2026, at 2:13 p.m. with the Director of Nursing (DON) Staff #76 who stated that the facility process during medication administration would be to protect resident information by covering documents with the resident's name. The DON stated that computer screens should be locked when providing medications to a resident, to prevent a breach of private information. The DON stated that staff were educated on minimizing and locking computer screens during medication administration. A review of the policy titled, Resident Rights, reviewed on June 1, 2020, revealed that the resident has the right of privacy and confidentiality. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. A review of the policy titled, Charting and documentation, reviewed on June 1, 2026, revealed that the information in the clinical record is confidential and may only be released in accordance with state law and the facility law.		

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 07/09/2026
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)		
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** Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure one of six sampled residents (#210) received a timely, monitoring, and treatment following a fall. The deficient practice delayed recognition of the resident's injury and delayed medical treatment resulting in prolonged pain, hospitalization and surgical hip repair of a right hip fracture. Findings include: Resident #210 was admitted on [DATE] with diagnoses including dementia, osteoporosis, paranoid schizophrenia, cognitive communication deficit, epilepsy, history of falling, and generalized muscle weakness. The fall risk assessment dated [DATE] revealed a score of 6.0, indicating a low fall risk. The MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 2, indicating severe cognitive impairment. Further, the assessment included that Resident #210 was independent for walking 10, 50, and 150 feet; and, did not use any assistive devices. The care plan revised on September 4, 2025, revealed the resident had a potential injury from falls, was high risk for falls, had difficulty ambulating, and was unsafe and unreliable to ask or wait for help. Interventions included assistance with ambulation, using a wheelchair as needed, observing, recording, and correcting all unsafe conditions, putting hip pads on the resident when she is out of bed due to falling history and recent fracture of the left hip and the left knee. The nursing progress note dated September 15, 2025 at 4am documented that the resident was wandering during the shift and was redirected as needed. Review of incident report involving Resident #210 dated September 15, 2025, revealed that the resident was noted to have had a fall in the hallway to the ground while she was being led to the dinner meal on September 15, 2025 at 5:40 p.m. The report indicated that the fall was witnessed by staff, and no injuries were observed post incident. Predisposing physiological factors included gait imbalance, impaired memory, recent change in medications/new medications, confusion, and incontinence. Predisposing situation factors included active exit seeking, wandering, and improper footwear. There was no evidence on the report regarding the immediate action that was taken, or pain level at the time of the incident. The report also indicated that the insurance case manager was notified two days after the fall occurred on September 17, 2025, and the Power of Attorney was notified on September 16, 2025, one day after the incident. There was no evidence the witnessed fall was reported to the licensed nurse at the time of the incident. Consequently, there was no evidence the resident received an immediate nursing assessment, evaluation, physician notification, or post-fall monitoring from 5:40 p.m. until 11:52 p.m. A medication administration note dated September 15, 2025 at 11:52 p.m. revealed that Resident #210 had pain score of 8 and was given narcotic medication for right leg pain. A medication administration note dated September 16, 2025 at 12:46 a.m. revealed the follow up pain score was a 6 and the pain medication was deemed ineffective due to the resident's pain being minimally relieved. The nursing progress note dated September 16, 2025, at 12:51 a.m. documented that the Certified Nursing Assistant (CNA) reported the resident had been resistant to care that evening and refused to transfer or stand, which was a change from the resident's usual baseline. A same nursing progress note dated September 16, 2025 at 12:51 a.m. revealed that at approximately 11:40 p.m., Resident #210 was yelling in her room; and that, the nurse found the resident lying in bed with a grimacing facial expression, crying out ow, and grabbing her right leg. The documentation also included that the resident's right leg appeared mildly externally rotated and shorter than the left leg, with no visible abnormality of the hip; and that, the resident cried out when the right hip was lightly palpated. There (continued on next page)		

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 07/09/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no bruising or skin discoloration noted. According to the documentation, the resident reported a pain level of 8 and received as-needed pain medication; and, the physician was notified, and orders and consent were obtained to transfer the resident to the hospital. Further, the documentation noted that the resident was transferred to the hospital on September 16, 2025, at approximately 12:25 p.m. The nursing progress note dated September 16, 2025 at 2:47 a.m. revealed a report was received that the resident had a fracture to the right hip and the resident would be admitted. The discharge MDS assessment dated [DATE] revealed that the resident had an unplanned discharge to an acute hospital with return to the facility anticipated. The nursing progress note dated September 16, 2025 at 10:48 a.m. documented that during the morning report the nurse on shift was notified by a CNA that the resident #210 had been assisted up from the ground in the hallway on September 15, 2025 at approximately 5:40 p.m. The documentation further indicated that while another CNA was leading the resident to dinner, the resident #210 lost balance and fell onto her right side in the hallway. According to the documentation, the resident was then assisted into a wheelchair by CNA's and provided dinner. However, there was no evidence of any such incident or the CNA reporting any incident to any staff prior to the morning of September 16, 2025. There was also no documentation of interventions put in place post fall. Review of Human Resources Personnel Action Notice for CNA (staff #121) dated September 16, 2025 revealed that the CNA's last scheduled working day was September 15, 2025 and was terminated September 16, 2025 due to being unsuccessful at maintaining compliance with facility policies and procedures on September 15, 2025 when she failed to properly utilize facility equipment while performing her job duty, failed to utilize proper techniques while performing her job duties and failed to properly notify. The response section revealed that the CNA indicated it was the end of the day and she was feeling overwhelmed and stressed; and that she rushed through the situation instead of following protocol. Hospital records revealed the resident sustained an acute displaced intertrochanteric fracture of the right hip requiring hospitalization and surgical repair. Review of a social services progress note dated September 19, 2025 revealed that the resident was re-admitted to the facility on [DATE] and the resident was anticipated to stay long term. During an interview conducted on July 7, 2026 at 11:55 a.m., CNA (staff #59) stated that after a fall occurs, she cannot leave a resident alone or help the resident until the nurse arrives to assess. An interview was conducted on July 9, 2026 at 12:44 p.m., with another CNA (staff #42) who stated that over the course of six months Resident #210 went from ambulating to breaking her hip. He stated that a staff member was walking her down the hall and the resident stumbled and fell. However, he said that he was not present during the incident. The CNA further stated that after the fall the resident was very dependent, required total care, and had a pretty slow decline. In an interview conducted with a Licensed Practical Nurse (LPN/staff #56) on July 9, 2026 at 12:52 p.m., the LPN (staff #56) stated that when a staff member is with a resident during a fall, the staff member gets the nurse, the nurse conducts neurological and physical checks, checking the resident's extremities, seeing if a leg is shorter than the other, seeing if the resident is showing any signs of pain upon palpation, and determines if the resident needs to be sent to the hospital/ER for a higher level of care. Regarding Resident #210, the LPN stated that Resident #210 had suffered a hip fracture, had failed to thrive, never walked again, and had a steady decline. During an interview conducted on July 9, 2026 at 2:41 p.m. with a Registered Nurse (RN/staff #27), who stated that during night shift on September 15, 2025, Resident #210 was in more pain than her baseline so she assessed the resident and gave her as needed pain medication. The RN also stated that the resident was assessed for vital signs, pain, and skin condition. The RN explained that the resident's leg was assessed based on how she was holding her body. The RN further stated that Resident #210 did go to the hospital that night. The RN also (continued on next page)		

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 07/09/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she did not know what happened to Resident #210 because the night shift staff did not get report of anything happening to Resident #210 from the CNAs (staff #121 and staff #122). During an interview conducted on July 9, 2026 at 4:26 p.m. with the Director of Nursing (DON/staff #76) and the Administrator (staff #1), the DON stated that initial fall risk assessments are conducted upon admission by asking the residents representative questions about any falls in the last thirty days and the last three to six months, if they have an increased risk of falling, it is included in the care plan. The DON stated that the primary difference between a witnessed and an unwitnessed fall is that an unwitnessed fall always requires neurological checks. The DON further stated that if a staff member witnesses a fall but does not follow facility procedures, corrective action may include progressive discipline and reeducation, as appropriate. The DON also stated that failing to report a fall to the nurse immediately could worsen the resident's injuries, increase pain, and delay necessary treatment. The Administrator (staff #1) stated that if a resident had a fall in the facility, staff investigates the fall, and revises the care plan with necessary interventions to attempt to prevent another fall. Immediately after a resident has had a fall, a nurse must assess the resident by taking vitals, conducting a brief skin assessment, assess for injuries, ensure the resident's safety, and determine if it is safe for the resident to be moved to their room for a more thorough skin assessment. Staff #1 also stated that staff would notify the physician, responsible party, case manager, and pharmacy consultant for any medication adjustments. Staff #1 further stated that care plan revisions are conducted within a few hours after the fall after the residents' needs are taken care of such as dressing wounds and if needed, being transported to another facility for further care. The DON stated that the only difference between unwitnessed and witnessed falls is that unwitnessed falls have a neurological check no matter what the situation is. The DON also stated that depending on the situation, if a staff member witnesses a fall and does not follow the facilities process, that corrective actions are put in place with progressive discipline and reeducation is conducted, if warranted. The DON further stated that the risks of a fall occurring and staff not reporting it to the nurse immediately include aggravating injuries with potential to injure the resident further and create increased pain for the resident. The Administrator stated that on September 15, 2025 the witnessed fall incident report was not as comprehensive due to the incident not being reported in a timely manner after it occurred. The Administrator also stated that the night nurse on September 15, 2025 had done an assessment on the resident and sent the resident to the hospital and when staff entered the facility on September 16, 2025 they did an investigation after being told by the hospital that the resident had sustained a hip fracture. The Administrator further stated that on September 16, 2025, a CNA (staff #121) reported that she had been leading Resident #210 down the hallway and the resident had fallen on the floor behind the CNA (staff #121) and that CNA (staff #121) and CNA (staff #122) then transferred the resident into a wheelchair and took her to dinner instead of notifying the nurse of the fall, to assess the resident prior to transferring. The Administrator further stated that CNA (staff #121) had been leading the resident incorrectly without a gate belt, that CNA (staff #122) had thought that the resident had been assessed by a nurse already, and staff's actions did not meet the facilities standards. The Administrator also stated that CNA (staff #121) was terminated due to not adhering to policies and procedures and that CNA (staff #122) was not terminated for helping CNA (staff #121) due to thinking that the nurse had already assessed the resident. The facilities policy titled, Post Fall Protocols and Reporting Incidents, revealed that if a fall is witnessed or a resident is found on the ground, the direct care staff member is to notify the nurse on duty, never move or pick up a resident without the nurse present, once the nurse has responded, gather equipment to obtain vital signs, once the nurse has completed an assessment and the staff member has been instructed, lift the resident (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the floor, if the fall was unwitnessed or there is a head injury, neuro checks will be completed for 72 hours. The facilities policy titled, Falls and Fall Risk Management, revealed that staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. The policy further revealed that if interventions have been successful in preventing falls, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has been resolved.		

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 07/09/2026
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interviews, facility documentation and policy, the facility failed to ensure necessary blood sugar medications were administered according to provider orders for one resident (#200) out of five sampled residents. The universe was 87. This deficient practice could put residents at the risk for not receiving medications as per the parameter. Finding include: Resident #200 was admitted on [DATE], with diagnosis including unspecified dementia with anxiety, post-traumatic stress disorder, type 2 diabetes mellitus (DM), and sleep apnea. A review of the care plan dated [DATE], revealed that the resident was at risk of fluctuating blood sugar related to DM. The interventions included checking blood sugar (BS) and administering insulin as per order or protocol. A physician order dated [DATE], was written for Humalog solution 100 UNIT/ML (Insulin Lispro), to inject subcutaneously before meals and at bedtime for diabetes as per sliding scale: if blood sugar is 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units, and to call provider if blood sugar is less than 70 and greater than 400. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 01, indicating severe cognitive impairment. The assessment further revealed that the resident had a diagnosis of DM and was receiving insulin. A review of the blood sugars, as noted on the vitals section of the electronic health record, on [DATE], at 11:01 a.m., revealed a blood sugar of 382 mg/dl (milligrams per deciliter) which was struck out by Registered Nurse (RN, Staff #70) on [DATE], at 12:42 p.m., with a rationale noted as "deceased". An observation was made on [DATE], at 11:01 a.m. Registered Nurse (RN, Staff #70) was preparing medications for Resident #200 and stated that resident is on sliding scale insulin and that the amount of insulin administered depends on the BS level. The RN was observed going to the resident's room at approximately 11:03 a.m. with an insulin pen of around 100 units, sterile lancet, and glucometer. The RN was then observed taking the resident's blood sugar which was observed to be 382, per the glucometer reading. The RN then notified the resident that he would receive 6 units of insulin. The RN was then observed dialing an insulin pen to 6 units and administering the 6 units to the resident. However, a Medication Administration Record (MAR), dated [DATE], at 11 a.m., revealed that the blood sugar for Resident #200 was 282 and that 4 units of insulin had been administered. An interview was conducted on [DATE], at 3:04 p.m., with the RN (Staff #70), who stated that she is a PRN (as needed) nurse and worked in the facility for a year. The RN stated that she provided medication administration, wound treatment, and conducted vitals for the residents. The RN stated that when taking BS, she would first review the order, then take the resident's blood sugar, then review the medication order again to determine the insulin units to be given to the resident. The RN then reviewed the medication order for Resident #200 and stated that resident had an order dated [DATE], which was written for Humalog solution 100 UNIT/ML (Insulin Lispro), and noted to inject insulin subcutaneously before meals and at bedtime for diabetes as per sliding scale: if blood sugar is 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units, and to call the provider if blood sugar is less than 70 and greater than 400. The RN then stated that Resident #200 BS was 382 on [DATE], at approximately 11 a.m. and that he was given 6 units instead of 8 units. The RN further stated that risk of administering residents insulin out of parameters could result in the residents feeling lethargic. An interview was conducted on [DATE], at 8:26 a.m., with a Licensed Practical Nurse (LPN) Staff #21, who stated that she provided wound treatment, vitals, and medication administration to residents. The LPN stated that for medication (continued on next page)		

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 07/09/2026
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration she would review the resident's order to identify which resident had diabetes. The LPN then stated that she would then take the resident's BS and review the order again to determine the amount of insulin units to be given to the resident. The LPN then stated that the risk if insulin were given out of parameters would include the resident being lethargic, sweating, and potentially hypoglycemic. An interview was conducted on [DATE], at 2:13 p.m. with the Director of Nursing (DON) Staff #76. The DON stated that the facility process for giving insulin to residents included checking the resident's blood sugar and that sliding scale insulin was given based on the provider orders and would be documented in the Medication Administration Record (MAR). The DON stated that values in the MAR would have to be struck out and re-input if values were to be changed at any point in time. DON stated that the risk, if insulin was given out parameter, could include not enough insulin given that the BS level would not go down enough to reach therapeutic levels and if too much insulin were given that it would exceed therapeutic levels. The DON reviewed the medication orders for Resident #200 and stated that resident had an order dated [DATE], written for Humalog solution 100 UNIT/ML (Insulin Lispro), and to inject the insulin subcutaneously before meals and at bedtime for diabetes as per sliding scale: if the blood sugar was 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units, and to call provider if blood sugar is less than 70 and greater than 400. The DON then reviewed the MAR for Resident #200 and stated that on [DATE], at 11:00 a.m., BS was noted as 282 with 4 units documented as administered; however, the observation on the date and time noted was that BS was 382 at 11 a.m. on [DATE], and that 6 units of insulin were observed to have been administered. The DON then reviewed the progress notes for Resident #200 and stated that the note did not show as struck out in MAR. The DON pulled up the resident vitals noting the BS and stated on [DATE], at 11:00 am a BS of 382 was struck out with a rationale noted as deceased. The DON stated that RN (staff #70) should have reported the medication error to the DON but she had not. DON further stated that there is no reason, without an order, to administer anything counter to the original order. The DON stated that the risk of inaccurate documentation included incorrect treatment from physicians, problematic charting for nurses following the resident to ensure that the resident received the appropriate care. The DON further stated that if medications were given out of parameter then the provider and family were notified and the staff would fill out the medication error report form. The DON then reviewed the clinical record for Resident #200 and stated that there is no evidence in the resident's clinical record that the provider was notified of insulin given out of parameter. A review of the policy titled, Medication Administration, reviewed on [DATE], revealed that all medications must be administered in accordance with the physician's orders including any and all time frames. The policy further revealed that orders will be checked for administrations and parameters and will be administered accordingly. A review of the policy titled, Following Physician Orders, reviewed on [DATE], revealed that the order will be verified by the nurse.		