STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035126	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of North Glendale	13620 North 55th Avenue Glendale, AZ 85304

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** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that residents are free from abuse from other residents. The deficient practice could result in residents being physically and emotionally injured. Findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, chronic kidney disease, liver disease, atherosclerotic heart disease, and other specified disorders of bone density and structure unspecified site. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact. A progress note dated August 13, 2024 revealed that this writer was at the nurse station at 6:40 p.m. when a certified nursing assistant (CNA) yelled out, no don't hit her, while rushing toward the incident. The CNA noticed the resident #37 with left hand balled onto a fist hitting the resident #11 by her left forearm. Nursing staff were immediately present at the incident, and both resident were separated. The Executive Director, Director of Nursing, medical doctor, the power of attorneys, and authorities were notified. This writer didn't notice any injuries upon the initial assessment of both residents. Nursing will continue to follow up with a psych assessment and present medication orders. Safety measures were put in place, both residents are in their rooms resting, and watching TV. Call-lights and bedside tables are within reach. The care plan dated August 14, 2024 revealed that the resident is/has the potential to be verbally/physically aggressive related to dementia, ineffective coping skills. Interventions included to analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. -Resident #37 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, anxiety disorder, and depression unspecified. The minimum data set (MDS) dated [DATE] revealed that the resident is not able to complete a brief interview for mental status. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated August 13, 2024 revealed that the resident got in verbal argument with another resident and punched her in the arm. Residents were separated, and the medical doctor and family made aware. The progress note dated August 13, 2024 revealed that the resident is to move rooms. The resident's son is aware and in agreement. New orders for labs were received. A progress note dated August 15, 2024 revealed that at approximately 6:43 p.m. a CNA witnessed this resident and another resident raising voices in the hallway. The CNA walked quickly to separate them both and before she could get to them, the CNA witnessed this resident took her left fist and hit the other resident in her left arm. The other resident grabbed this resident's hand and CNA got to them and separated them immediately. Residents were separated immediately, no injuries bruises/redness noted to this resident's arm. The Executive Director, Director of Nursing, medical doctor, and the family were notified. This resident was moved to station 4, and the family was notified of the transfer. The care plan dated August 16, 2024 revealed that the resident is/has the potential to be physically aggressive related to anger, dementia. Interventions included that the resident needs personal space. The resident reacts to touch. When the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Review of a written statement dated August 13, 2024 by a certified nursing assistant (CNA/staff #7), revealed that resident #11 was in the hall and resident #37 stopped her and they started arguing. Resident #37 took left fist and struck resident #11 on the left forearm. Resident #11 grabbed resident #37's arm and when the CNA got to the residents, resident #11 let go of resident #37's arm. Review of a written statement dated August 13, 2024 revealed that a licensed practical nurse (LPN/staff #41) revealed that she heard the two residents raising their voices in the hallway. A (CNA) went to separate the residents, but before she could get to them, resident #37 raised her hand and grabbed/hit the other resident #11 in the arm. The CNA separated them right away, and no injuries were noted on either resident. Then resident #37 was moved to the fourth floor. Review of a written statement dated August 13, 2024 revealed that (CNA/staff #54) was standing by room [ROOM NUMBER] when she saw resident #37 hit resident #11's chair and says something to resident #11 in her language, while making gestures with her hands. Resident #11 had resident #37's right arm very tightly, because she could see the force that resident #11 was exerting on resident #37's arm and then (CNA/staff #7) screams, they are fighting. Staff #54 stated that they all know that resident #11 doesn't share her space with anyone, and since resident #37 hit her chair, she was angry and became aggressive with resident #37. An interview was conducted on August 27, 2024 at 12:16 p.m. with a licensed practical nurse (LPN/staff #23), who stated that she has received training on abuse and physical abuse includes striking, grabbing, and pulling. She stated that resident #11 needs supervision because she wanders. She stated that she did not witness the altercation, but knows that one of the residents was transferred to the fourth floor. (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 August 28, 2024 at 9:05 a.m. with the Director of Nursing (DON/staff #1), who stated that abuse occurs when harm is inflicted on a resident and can be physical, mental, misappropriation, isolation, restrained, and sexual. She stated that a 5-day investigation was completed and the allegation of abuse was substantiated. The two residents didn't like each other, which only became apparent during the incident. The facility policy, Abuse Prevention revised June 17, 2024 states that it is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.