

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/27/2024
NAME OF PROVIDER OR SUPPLIER  Maryland Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  31 West Maryland Avenue Phoenix, AZ 85013	

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>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341</b></p> <p>Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to ensure one resident (#4) was not abused by another resident (#5). The deficient practice could result in residents being abused.</p> <p>Findings include:</p> <p>-Regarding Resident #4:</p> <p>Resident #4 admitted to the facility on [DATE] with diagnosis that included Post Traumatic Stress Disorder, alcohol abuse, depression and pain.</p> <p>The Minimum Data Set (MDS) assessment from May 30, 2024 revealed that the resident's Brief Interview for Mental Status (BIMS) score was 09 which indicated moderate cognitive impairment. The assessment also revealed that the resident had verbal behaviors directed towards others 1 to 3 days during 7 day look back period</p> <p>Care plan initiated on June 15, 2024, Resident #4 was care planned for legal blindness and extreme hard of hearing.</p> <p>A progress note from July 16, 2024 documented a change in condition due to Resident #4 and Resident #5 becoming verbally aggressive with each other. Resident #4 alleged he had been hit in the face by Resident #5. Resident #5 stated he did hit Resident #4 because resident hit him first.</p> <p>A month later on August 13, 2024, another change of condition note was entered regarding a resident to resident altercation with Resident #4 and Resident #5 again. The note stated Resident found on ground, laying on right side in fetal position following an altercation with another resident.</p> <p>There were no changes to the resident #4's care plan post incident on July 16 and/or August 13, 2024</p> <p>-Regarding Resident #5:</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #5 admitted to the facility on [DATE] with diagnosis that included schizophrenia, bipolar disorder, anxiety disorder, delirium due to physiological condition, altered mental status, disorientation and cognitive communication deficit.</p> <p>The MDS assessment dated [DATE] revealed resident #5's BIMS score was 13, which indicated he was cognitively intact. The assessment revealed resident #5 had physical behaviors directed towards others 1 to 3 days in a 7 day look back period.</p> <p>The Care plan initiated on February 19, 2024 revealed resident #5 was care planned for being physically abusive with interventions that included identifying triggers.</p> <p>In a progress note dated August 13, 2024 included a nursing observation that stated Resident was seen sitting in wheelchair outside of room with door open yelling with a cane in his hand which appeared as though he was trying to hit another resident who was on the ground in front of his room door.</p> <p>A follow up note the same day documented that the alleged perpetrator was moved to a different room for safety concerns.</p> <p>Review of resident #5 record revealed no interventions for the incident on 07/16/24 and/or 08/13/2024 on his care plan.</p> <p>In an interview with licensed practical nurse (LPN/ Staff #23) on August 27, 2024 at 2:05 pm, she stated that she had witnessed the August altercation between Residents #4 and #5. She stated she heard yelling, saw resident #4 on the ground and resident #5 was holding his cane. She stated she checked resident #4 for injuries, asked what happened to which he stated he had gotten lost (resident is blind) and was using his white cane when Resident #5 opened the door onto him and pushed him down. Staff #23 said resident #4 stated resident #5 beat him up. Staff #23 stated that while she did not see resident #5 physically hit Resident #4, when she asked him if he had, resident #5 said yes, it was intentional, and that he was trying to harm resident #4. She stated they also had a history of altercations and staff in general know not to keep the two of them together.</p> <p>Resident's #4 and #5 were not available for interview.</p> <p>In an interview with the Director of Nursing (DON/ Staff #12) on August 27, 2024 at 2:29 pm, she stated that in instances of resident to resident altercations, her expectations are that if there is physical contact, then the facility will report to Department of Health, Adult protective services, and guardians if applicable. The DON stated that the staff will conduct a skin check and send the resident out for injuries they may have sustained. The DON further stated a follow up would be to get new orders and update the care plan.</p> <p>In a policy titled Resident to Resident Altercations last revised December 2016, it states If two residents are involved in an altercation, staff will: Review the events with the Nursing Supervisor and Director of Nursing, and possible measures to try to prevent additional incidents; Make any necessary changes in the care plan approaches to any or all of the involved individuals; Document in the resident's clinical record all interventions and their effectiveness; Consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the Attending Physician or Interdisciplinary Care Planning Team.</p>		