

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  12/04/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50116</p> <p>Based on observations, clinical record reviews, interviews and policy review, the facility failed to ensure an accessible bathroom was readily available for resident use for two residents (#34 and #46); and, failed to ensure that the bathroom of two residents (#23 and #28) were not used by other residents. The deficient practice could result in residents not receiving necessary assistance to help maintain their independence. The Census was 55.</p> <p>Findings include:</p> <p>-Resident #34 was admitted on [DATE] with diagnoses of hypertension, cerebrovascular accident, depression and bipolar disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed that the resident may need extra help with specific activities, had experienced social isolation on rare occasions and was receiving an antidepressant.</p> <p>-Resident #46 was admitted on [DATE] with diagnoses of major depressive disorder, unspecified hearing loss, and personal history of traumatic brain injury.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, which indicated the resident had moderate cognitive impairment.</p> <p>-Resident #28 was admitted on [DATE] with diagnoses of chronic systolic (congestive) heart failure, type 2 diabetes mellitus, and mild stage 2 chronic kidney disease.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated the resident had moderate cognitive impairment.</p> <p>The bedroom of resident #28 was located on the south side next to the dining room; and, this is one of the resident bathrooms that residents #34 and #46 use.</p> <p>-Resident #23 was admitted on [DATE] with diagnoses of schizoaffective disorder, bipolar type, post-traumatic stress disorder, and difficulty walking.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated the resident had moderate cognitive impairment.</p> <p>The resident's bedroom was located on the north side next to the dining room; and, this is one of the resident bathrooms that residents #34 and #46 use.</p> <p>An observation was conducted on December 4, 2024 at 11:21 a.m. and revealed there were two residents were in the dining room. The tables and chairs were not placed in the main dining room area for the residents to eat at. The tables were in front of the kitchen food serving area, with the dining room chairs stacked up together. Uncovered white clothing racks were placed around the dining room walls. There were no bathrooms for residents to use inside the dining room area; and, no public restroom located immediately outside of the dining room.</p> <p>An attempt to interview resident #46 was conducted on December 4, 2024 immediately following the observation but the resident refused.</p> <p>An interview was conducted on December 4, 2024 at 11:32 a.m. with resident #34 who stated that he had been living in the dining room for about one month; and that, there were five to six other residents (male) who had been staying in the dining room with him. Resident #34 further stated that he had to use another resident's bathroom when he needed to.</p> <p>An interview was conducted on December 4, 2024 at 12:43 p.m. with a Staffing Coordinator (staff #48) who stated that there were no bathrooms available for resident use in the dining room.</p> <p>An interview with Director of Nursing (DON/staff #57) was conducted on December 4, 2024 at 1:13 p.m. The DON stated that residents using the dining room as their bedroom need to use another resident's bathroom since their own room had been sealed off for remodeling. The DON said that there were two male resident rooms located on either side of the dining room; and that, the residents in these rooms had agreed to let residents #34 and #28 use their bathrooms.</p> <p>A random interview was conducted on December 4, 2024 at 2:35 p.m. with resident #28 who stated that his room was remodeled maybe a month ago; and that, the residents who were currently staying in the dining room were using his bathroom.</p> <p>An interview was conducted on December 04, 2024 at 2:38 p.m. with resident #23 who stated that he resident was pleased with the update of his room; and that, his room now was more homey. He said that his new bathroom was being used by other residents who were not as clean as him. Further, resident #23 stated that nobody likes to find feces on the toilet seat and he had to wipe feces off of the toilet seat.</p> <p>The facility's policy on Activities of Daily Living (ADLs) revealed that residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50116</p> <p>Based on observations, clinical record reviews, interviews and policy review, the facility failed to ensure a safe, comfortable and homelike environment was provided to two residents (#34 and #46). The deficient practice could result in residents' preferences were not honored and residents being prevented from having individualized area. The census was 55.</p> <p>Findings include:</p> <p>-Resident #34 was admitted on [DATE] with diagnoses of hypertension, cerebrovascular accident, depression and bipolar disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed that the resident may need extra help with specific activities, had experienced social isolation on rare occasions and was receiving an antidepressant.</p> <p>A psychiatric note dated November 26, 2024 included the resident was alert and oriented x 4.</p> <p>-Resident #46 was admitted on [DATE] with diagnoses of major depressive disorder, unspecified hearing loss, and personal history of traumatic brain injury.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, which indicated the resident had moderate cognitive impairment.</p> <p>An observation on December 4, 2024 at 11:21 a.m. the facility had one dining room for the 55 residents that were residing in the skilled and long term care units. The tables and chairs were not placed in the main dining room area for the residents to eat at; and, the tables were in front of the kitchen food serving area, with the dining room chairs stacked up together. There were two hospital-type beds in the dining room that were used by two residents (#34 and #46). The beds had black screens which were approximately 2 feet on the left and right sides of the bed and approximately a foot from the end of the bed. An uncovered white clothing racks were placed around the dining room walls. There were no bathrooms/restrooms readily available for resident use inside of the dining area. There was also no call light system in the dining room. Regarding resident #34's area in the dining, there were black privacy screens with rolling wheels on the left and the right side of the bed. The head of the bed was against the window; and, there was a black screen over the window. The black privacy screen at the foot of the bed was open and resident #34 was laying in the bed. At this point of the observation, resident #34 asked for privacy and the staff present in the room then pulled the black privacy screen closed. Regarding resident #46, the resident, his belongings, hospital-type bed, recliner and bedside table was in the alcove of the dining room which was approximately 8 feet deep and 5 feet wide. Resident #46 was sitting in a recliner next to his bed.</p> <p>An attempt to interview resident #46 was conducted on December 4, 2024 immediately following the observation but the resident refused.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on December 4, 2024 at 11:32 a.m. with resident #34 who stated that he had been living in the dining room for about one month; and that, there were five to six other residents (male) who had been staying in the dining room with him. Resident #34 further stated that he had to use another resident's bathroom when he needed to; and that, there were no call light to use in the dining room. The resident stated that he had to wait for someone to walk by or he would snap his fingers to get the attention of the staff.</p> <p>An interview with the cook (staff #53) was conducted on December 4, 2024 at 12:28 p.m. The cook stated the facility was doing renovations of resident rooms; and, the residents affected (#34 and #46) were using the dining room as their bedrooms. The cook said that the other residents not affected by the renovation were either eating outside in the patio or in their rooms. The kitchen Manager (staff #31) joined the interview and stated that there were no residents eating in the dining room; and that, residents #34 and #46 had been using the dining room as their bedroom for about one month now.</p> <p>A random interview was conducted on December 4, 2024 at 12:33 p.m. with a female resident (#35) who stated that she had been eating her meal outside in the patio at the picnic tables while the cafeteria was getting fixed. She stated that there were about six residents at a time staying in the dining room because there were 2 rooms being renovated at a time. She said that each of these rooms had 3 residents.</p> <p>An interview was conducted on December 4, 2024 at 12:43 p.m. with a staffing coordinator (staff #48) who stated that there were no call lights or bathrooms in the dining room.</p> <p>In an interview conducted with Director of Nursing (DON/staff #57) on December 4, 2024 at 1:13 p.m., the DON stated that residents using the dining room as their bedroom need to use another resident's bathroom since their own room had been sealed off for remodeling/renovation. The DON said that there were two male resident rooms located on either side of the dining room; and that, the residents in these rooms had agreed to let residents #34 and #28 use their bathrooms.</p> <p>An interview was conducted on December 4, 2024 at 2:38 PM with resident #23 who stated that he resident was pleased with the update of his room; and that, his room now was [NAME]. Resident #23 stated that his new bathroom was being used by other residents.</p> <p>Review of the facility policy on Resident Rights included that employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to a dignified existence, be treated with respect, kindness and dignity, and privacy and confidentiality.</p> <p>The facility's policy on Activities of Daily Living (ADLs) revealed that residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50116</p> <p>Based on observations, clinical record reviews, interviews and policy review, the facility failed to ensure an accessible, working call light was available for use for two residents (#34 and #46). The deficient practice could result in residents not having the means to communicate with staff. The census was 55.</p> <p>Findings include:</p> <p>-Resident #34 was admitted on [DATE] with diagnoses of hypertension, cerebrovascular accident, depression and bipolar disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed that the resident may need extra help with specific activities, had experienced social isolation on rare occasions and was receiving an antidepressant.</p> <p>A psychiatric note dated November 26, 2024 included the resident was alert and oriented x 4.</p> <p>-Resident #46 was admitted on [DATE] with diagnoses of major depressive disorder, unspecified hearing loss, and personal history of traumatic brain injury.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, which indicated the resident had moderate cognitive impairment.</p> <p>An observation on December 4, 2024 at 11:21 a.m. the facility had one dining room for the 55 residents that were residing in the skilled and long term care units. The tables and chairs were not placed in the main dining room area for the residents to eat at; and, the tables were in front of the kitchen food serving area, with the dining room chairs stacked up together. There were two hospital-type beds in the dining room that were used by two residents (#34 and #46). The beds had black screens which were approximately 2 feet on the left and right sides of the bed and approximately a foot from the end of the bed. An uncovered white clothing racks were placed around the dining room walls. There was also no call light system in the dining room.</p> <p>An attempt to interview resident #46 was conducted on December 4, 2024 immediately following the observation but the resident refused.</p> <p>An interview was conducted on December 4, 2024 at 11:32 a.m. with resident #34 who stated that he had been living in the dining room for about one month; and that, there were no call light to use in the dining room. The resident stated that he had to wait for someone to walk by or he would snap his fingers to get the attention of the staff.</p> <p>In another interview with resident #34 conducted on December 4, 2024 at 12:47 p.m., the resident stated that he had to wait for someone to walk by to get a hold of the nurse and had to snap fingers, since there were no call lights in the dining room to use for help. Further, resident #34 said that it would take a few minutes to an hour to get assistance from staff.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on December 4, 2024 at 12:40 p.m. with the Maintenance Director (staff #34) who said that there was no call light or call bells located in the dining room.</p> <p>In an interview with the staffing coordinator (staff #48) conducted on December 4, 2024 at 12:43 p.m., the staffing coordinator said that she did not remember when the housing in the dining room started; but, she had scheduled a certified nurse assistant (CNA) in the area for the past couple of weeks.</p> <p>An interview with a CNA (staff #6) was conducted on December 4, 2024 at 12:53 p.m. The CNA stated that residents had been housed in the dining room for one month; and that, there could have been up to eight residents residing at a time in the dining room. The CNA stated that there were no call lights available for the residents to use in the dining room; but, a CNA would be stationed in the dining room, stay in the dining room for one hour and then swap out with another CNA.</p> <p>An interview was conducted with the Director of Nursing (DON/staff #57) on December 04, 2024 at 1:13 p.m. The DON said that the renovations had been going on for one month and it takes from one week to three weeks if plumbing needs to be replaced. The DON stated that all of the resident's belongings goes in with them to the dining room, so the residents have all of the items they need. The DON said that staffing was increased so a CNA can be in the dining room with the resident at all times. Further, the DON stated that in the area where the CNAs were stationed, the CNAs should be able to see the residents; and that, the CNAs should be up interacting with the residents. The DON further stated that the CNAs had radios to notify the nurse and activate other staff should they need assistance or there was an emergency.</p> <p>Review of the facility policy on Resident Rights included that employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to a dignified existence, be treated with respect, kindness and dignity, and privacy and confidentiality.</p> <p>The facility's policy on Activities of Daily Living (ADLs) revealed that residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs.</p>		

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<p>F 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.</p> <p>50116</p> <p>Based on observations, clinical record reviews, interviews and policy review, the facility failed to provide a designated room to accomodate resident dining while undergoing renovations. The deficient practice could result in residents individual needs and preferences not accommodated. The census was 55.</p> <p>Findings include:</p> <p>An observation on December 4, 2024 at 11:21 a.m. the facility had one dining room for the 55 residents that were residing in the skilled and long term care units. The tables and chairs were not placed in the main dining room area for the residents to eat at; and, the tables were in front of the kitchen food serving area, with the dining room chairs stacked up together. There were two hospital-type beds in the dining room and there were black screens approximately 2 feet on the left and right sides of the bed and approximately a foot from the end of the bed. An uncovered white clothing racks were placed around the dining room walls. The dining room was used as a bedroom by two residents</p> <p>An interview was conducted on December 4, 2024 at 11:32 a.m. with one of the residents residing in the dining room. The resident stated that he had been living in the dining room for about one month; and that, there were five to six other residents (male) who had been staying in the dining room with him.</p> <p>An interview with the cook (staff #53) was conducted on December 4, 2024 at 12:28 p.m. The cook stated the facility was doing renovations of resident rooms; and, the residents affected (#34 and #46) were using the dining room as their bedrooms. The cook said that the other residents not affected by the renovation were either eating outside in the patio or in their rooms. The kitchen Manager (staff #31) joined the interview and stated that there were no residents eating in the dining room; and that, two residents had been using the dining room as their bedroom for about one month now.</p> <p>An interview was conducted on December 4, 2024 at 12:33 p.m. with a female resident who stated that she had been eating her meal outside in the patio at the picnic tables while the cafeteria was getting fixed. She stated that there were about six residents at a time staying in the dining room because there were 2 rooms being renovated at a time. He/she said that each of these room had 3 residents.</p> <p>Another interview was conducted on December 4, 2024 at 12:35 p.m. with another resident who stated that all meals were eaten outside of the dining room; and that, nobody can eat inside the dining room right now.</p> <p>In an interview conducted with another resident on December 4, 2024 at 12:37 p.m., the resident pointed to an area where a picnic table was and stated that it was the area where the birds don't S**t on it and that was where he eat their meals. The resident further stated that residents at the facility do not eat inside the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on December 4, 2024 at 12:53 p.m. with a Certified Nursing Assistant (CNA/staff #6) who stated that the residents usually eat outside in the patio or go in their rooms. The CNA said that some residents can eat in the dining room, but resident do not do this all the time when there are residents staying in the dining room.</p> <p>An interview was conducted with the Director of Nursing (DON/staff #57) on December 4, 2024 at 1:13 p.m. The DON said that the renovations had been going on for one month and it takes from one week to three weeks if plumbing needs to be replaced. The DON stated that when residents attempt to enter the dining room, they were redirected since there were residents residing inside the dining room. The DON said that for the most part, the residents do not go into the dining room if the residents were looking for activities.</p> <p>The Resident's Right policy reveals that the resident's have the right to a dignified existence, be treated with respect, kindness and dignity.</p> <p>The facility's policy on Activities of Daily Living (ADLs) revealed that residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs.</p>		