

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 01/08/2025
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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on clinical record review, interviews, observations, facility documentation, and policies, the facility failed to ensure that a resident was not abused by another resident for 2 of 3 sampled residents (#1 and #3). The deficient practice could result in continued psychosocial and/or physical harm to resident.</p> <p>Findings Include:</p> <p>-Regarding Resident #1:</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis affecting the right side, aphasia, major depressive disorder, cerebral infarction, and chronic kidney disease.</p> <p>A care plan dated February 12, 2024, revealed that the resident has a communication problem due to expressive aphasia with an intervention in place that Resident #1 is able to communicate by answering yes/no questions, hand gestures, and utilizing a communication book. Additionally, an intervention was to validate Resident #1's message by repeating aloud.</p> <p>An additional care plan revised April 04, 2024, revealed that Resident #1 has a behavioral problem and can demonstrate physical aggression toward others, with resident-to-resident incidents listed on June 6 and June 18, 2023. Interventions included intervene as necessary to protect the rights and safety of others, and to document behavior and possible causes. There was no evidence of an update to the care plan for an incident occurring January 4, 2025.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.</p> <p>A physician order dated January 4, 2025, revealed a change in condition for: redness/ mild edema to left eye orbital, and that the provider was notified.</p> <p>A review of the resident's clinical record revealed no evidence of any progress notes on January 4, 2025, that described an incident involving Resident #1.</p> <p>There was no evidence of a physician order for one to one staff monitoring for Resident #1.</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>A review of the facility's Incident Report Log revealed no evidence of any incident report for Resident #1 on January 4, 2025.</p> <p>A facility Reportable Incident Self-Report submitted to the state health department on January 4, 2025 at 10:06 AM, revealed that at approximately 9:00 a.m., on January 04, 2025, a nurse (Staff #14) notified the Administrator (Staff #55) and the Assistant Director of Nursing (ADON / Staff #31) that Resident #1 had slight redness to his eye. The report revealed that the resident is difficult to understand due to aphasia, however said something like "[NAME]" and was hitting/making hitting actions to his left eye. Further, the report revealed that we cannot tell if the redness in his left eye is from being struck by another resident or from Resident #1 hitting himself. The report revealed that an additional staff member has been placed to provide consistent observation between Resident #1 and his two roommates.</p> <p>The SBAR Communication Form dated January 04, 2025, revealed that a change in condition for Resident #1 happened on January 04, 2025, and that under the patient evaluation section titled Behavioral Evaluation the box was checked for Not clinically applicable to the change in condition being reported. Further, under the section Neurological Evaluation, the box was checked for not clinically applicable to the change in condition being reported. Additionally, under the section titled Skin Evaluation, a box was checked for Abrasion, with an additional description provided: noted redness/ mild swelling to the left eye orbital; no pain - will monitor unless otherwise instructed by MD. The note contained no evidence or description as to how the redness and mild swelling to the resident's left eye occurred.</p> <p>-Regarding Resident #3:</p> <p>Resident #3 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of brain, brief psychotic disorder, and acute kidney failure.</p> <p>A Health Status note dated January 4, 2025, at 2:56 PM, revealed that Resident #3 is on a change in condition for his new admission to the facility. Patient is alert and oriented x 4. Patient is able to make needs known verbally. There was no evidence in the note that the resident was on one to one staff monitoring.</p> <p>There was no evidence of progress notes dated January 4, 2025, documenting a resident to resident incident involving Resident #3.</p> <p>A Physician Progress Note dated January 4, 2025, signed by the Medical Director (Staff #18), revealed that Resident #3 has already been in physical confrontation apparently, and that Behavioral health will be consulted for his aggressive behavior and psychosis.</p> <p>A Health Status Note dated January 5, 2025, revealed that Resident #3 was on a change of condition for a resident to resident altercation. The note stated resident was agitated and noncompliant with medication and vital signs. The note stated the reesident has a one to one staff for monitoring and has no physical or verbal aggression toward peers / staff this shift thus far.</p> <p>A Health Status Note dated January 6, 2025, revealed that Resident #3 was transported out to the hospital to be assessed for altered mental status, aggression, and combativeness with staff and residents, and undressing.</p> <p>(continued on next page)</p>		

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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>A physician order dated January 6, 2025, indicated to send the resident out to the hospital due to altered mental status, possible infection, highly aggressive behaviors, and combativeness.</p> <p>There was no evidence of a physician order for one to one staff monitoring.</p> <p>The resident's baseline care plan, signed January 8, 2025, revealed an initial goal for coping skills and adjustments to situations and new environments, with an intervention to refer to psychiatrist/Psychologist as indicated. There was no evidence of a care plan update to address the resident's aggressive or combative behaviors.</p> <p>A formal request was made to the facility on [DATE], for any written statements from staff members or witnesses and any investigation interviews regarding the incident involving Resident #1 that occurred on January 4, 2025. The facility administrator signed a statement that the facility had none to date.</p> <p>However, despite this signed statement of having no written statements or interviews on January 8, the facility submitted a 5-day investigation report to the state health department on January 10, 2025. The investigation report revealed the following documented interviews:</p> <p>-January 4, 2025: A phone interview between the Administrator and Resident #1</p> <p>-January 4, 2025: An additional phone interview between the Administrator and Resident #1, where Resident #1 performed a hitting motion toward his eye and stating [NAME] [NAME].</p> <p>-January 5, 2025: An interview between Resident #1 and staff where Resident #1 identified by pointing that Resident #3 was the individual that [NAME] [NAME] on him.</p> <p>-January 6, 2025: An additional interview between the Administrator and Resident #1.</p> <p>Additional undated interviews included in the 5-day investigation report revealed:</p> <p>-The ADON (Staff #31) and Human Resources staff interviewed a Certified Nursing Assistant (CNA/ Staff #90), who was the assigned CNA during the shift of the alleged incident. Staff #90 stated that she did not witness the incident between the residents but overheard yelling and went to investigate. Resident #1 was outside of his room heading back to his room, and was stating repeated expletives, while making hitting motions toward his eye and stating [NAME], [NAME], [NAME]. Staff #90 asked if Resident #1 was hit and he shook his head, yes. She followed Resident #1 to his room and noticed that Resident #3 was sitting on Resident #1's bed. Staff #90 called on the radio for assistance from the nurse, and the nurse came. As both staff were getting Resident #3 back to his room, Resident #1 was pointing at Resident #3 and stating expletives and [NAME], [NAME]. The staff took statements from each resident after separating them to each of their rooms. Resident #1 stated he was struck by Resident #3. Resident #3 stated that Resident #1 kicked him in the balls 4 times.</p> <p>-The ADON and Human Resources staff interviewed a licensed practical nurse (LPN/ Staff #2) the assigned nurse to Resident #1 and Resident #3 on the night shift of the alleged incident, January 3 - 4, 2025. The interview revealed that the LPN stated that both residents are claiming the other struck them (that Resident #1 was struck in the eye by Resident #3, and that Resident #3 was kicked multiple times by Resident #1).</p> <p>(continued on next page)</p>		

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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>-The Administrator interviewed an LPN (Staff #14), who stated she did not witness the event but that she saw Resident #1 had slight redness to his eye. Resident #1 kept telling her [NAME] and pointing or making a hitting motion to his eye.</p> <p>Additionally, the facility 5-day investigation report revealed that the redness on Resident #1's eye appears to be self-inflicted (from rubbing or touching it) rather from blunt force trauma (being struck by something).</p> <p>An Employee Coaching Form signed January 6, 2025, for the LPN (Staff #2) revealed that the nurse was being terminated. The nurse failed to complete admission requirements for a new resident and failed to report potential resident to resident altercation within the timeframe specified.</p> <p>An interview was conducted on January 8, 2025, at 10:11 AM, with a CNA (Staff #12), who stated that she was familiar with Resident #1, and that he is territorial with his belongings in his room and that he had an altercation with the new resident in his room. She stated that the night shift CNA (Staff #90) told her about the incident. Staff #12 stated that she had heard that the other resident hit Resident #1 in the eye. She stated that Resident #1 would not hit himself in the face.</p> <p>An interview was conducted on January 8, 2025, at 10:15 AM, with the CNA (Staff #90) who was assigned to the residents at the time of the incident. She stated she was in a nearby room providing care to another resident with the door open. She stated that she was not sure of the time, but that it was around 5:00 AM on January 4, 2025, that she heard Resident #1 coming out of his room yelling I hate you along with the expletive motherf****. Staff #90 stated that she went to see what was wrong, and that Resident #1 was slouched over in his wheelchair in the doorway of his room facing his bed. She stated that she observed Resident #3 in Resident #1's room, sitting on his bed, and wearing Resident #1's jacket and pants. She stated that she called on the radio for the nurse to come assist. She stated that Resident #1 was unresponsive at first, then appeared to regain consciousness. She stated that then the nurse arrived and that Resident #3 was redirected to his room. She stated that Resident #1 was gesturing to indicate that Resident #3 had hit him. She stated that Resident #3 admitted multiple times to hitting Resident #1 and that he further stated that he only hit him because he hit me in the balls. Staff #90 further stated that after the incident that shift, that Resident #1 was very agitated and angry afterward, that he kept bringing up the situation. After the incident, Staff #90 stated that the nurse had told her to make sure that the two residents don't talk to each other, but that Staff #90 then stated back to the nurse that she had to do her round assignments, and that the nurse left it at that. Staff #90 stated that she asked the nurses at the nurse's station what she should do, and that she was advised to make a written statement of the incident and to leave it in the cubby at the nurse's station. Staff #90 stated that a room change was not done, but that staff started a one-to-one monitoring of the residents the following morning shift.</p> <p>A telephonic interview was conducted with an LPN (Staff #14) on January 8, 2025 at 10:40 AM. Staff #14 stated that she arrived for her shift at approximately 6:00 AM on January 4, 2025, after the alleged incident involving Residents #1 and #3 had occurred. She stated that she was informed by the night nurse that there was an allegation that Resident #1 was hit by another resident. She stated that a little later in her shift, she noticed that Resident #1 had redness and swelling to his left eye. She stated that she followed up with the Director of Nursing and the Administrator to make sure that it was reported. She stated that she also notified the Medical Director. The LPN stated that the facility placed a one to one monitor on the residents as soon as we could on my shift.</p> <p>(continued on next page)</p>		

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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>A telephonic interview was conducted on January 8, 2025, at 12:50 PM, with the facility's Medical Director and on-call physician (Staff #18). The Medical Director stated that he recalled being notified of the resident-to-resident physical altercation on January 4, 2025, and that it involved a potential head injury on Resident #1.</p> <p>A telephonic interview was conducted on January 8, 2025, at approximately 2:21 PM, with an LPN (Staff #28), who was the residents' assigned night shift nurse the following night after the incident. Staff #28 stated that I was told there was a resident-to-resident altercation and that Resident #1 was on a change of condition status. She additionally stated that he had bruising on the area of his eye, and that she noticed it the day after it happened.</p> <p>An observation was conducted on January 8, 2025, at 2:33 PM, of Resident #1 in his wheelchair in his room. Resident #1 consented to having the surveyor and a nurse observe his face. On the inside aspect of Resident #1's left eye, on the skin between his eye and his nose, was purple colored bruising. His right eye had no discoloration present.</p> <p>An interview was conducted with Resident #1 at this time. When asked if the resident recalled getting into an incident with another resident, Resident #1 clearly stated yes, then some unintelligible words, and then [NAME], [NAME], [NAME], and motioned toward his face with his fist without making actual contact. When asked who did that?, Resident #1 pointed toward the room of where Resident #3 had resided.</p> <p>An interview was conducted with an LPN (Staff #40) on January 8, 2025, at 2:44 PM, who came to Resident #1's room together for an observation of the resident's face. Regarding the marking on the inside of Resident #1's left eye, Staff #40 stated that she saw discoloration and that she further described the color as diminished purple. Staff #40 stated that she was not sure what the discoloration was from because she was off of work for a few days, but that she knew he had a resident-to-resident altercation. She further stated that she believed the other resident involved in that incident was Resident #3.</p> <p>An interview was conducted on January 8, 2025, at 3:08 PM, with the ADON (Staff #31), who stated that if there is an allegation of abuse, that the facility staff is to respond by separating the two residents, and to report the allegation to the mandatory reporting agencies within a 2-hour window. The facility staff is to protect the residents either through increased supervision, or room changes, or through one to one staff monitoring. A skin assessment is done on the residents, and an incident report should be completed, along with a progress note describing the incident. She stated that if staff did not complete an incident report or document the incident in a progress note, that it would not meet her expectations. When reviewing the medical record of Resident #1 together, the ADON stated that she did not see any notes describing the resident to resident incident. She stated that in regard to the incident, that she did the interview with the nurse (Staff #2), and that there was an allegation of a resident-to-resident incident, but that she was not sure that it happened. She stated that the nurse did not report it to her within the mandatory 2-hour timeframe. She then stated that Staff #2 was terminated for failing to let the facility know of the alleged abuse timely.</p> <p>(continued on next page)</p>		

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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>An interview was conducted on January 8, 2025, at 3:40 PM, with the Director of Nursing (DON/ Staff #63). The DON stated that the facility's process if there is an alleged abuse incident is for staff to notify the clinical managers, to notify the physician, notify the patient's guardian or power of attorney, to complete a risk management (incident report), to place any new orders from the physician, and to place the resident on a change of condition for 72 hour monitoring. The DON stated that the facility then investigates the incident by talking to residents and staff to see what happened, and that a progress note is completed, and a report made to the required reporting agencies. The facility protects the residents after an alleged abuse incident by placing the residents on one to one staff monitoring or providing a room change or by frequent monitoring. The DON further stated that her expectation is for staff to provide documentation in the clinical record of what they observed, to provide statements, to document any injuries, and what action was taken.</p> <p>The DON stated that regarding incident between Resident #1 and #3 on the night between January 3 and 4, 2025, that the Administrator had called her about a potential resident-to-resident allegation of abuse. She stated that we don't know if it truly happened, and that the night nurse did not report the incident within the 2 hours.</p> <p>The clinical record of Resident #1 was reviewed together at that time with the DON. The DON stated that she did not see any progress note about the incident, and that it would not meet her expectation for documentation of an alleged incident. She additionally confirmed that a risk management (incident report) had not been completed. She stated that the night nurse was terminated for not reporting the incident timely. The DON stated that at approximately 10:27 AM after the incident was when she called the staffing coordinator to ensure that one-to-one monitoring was in place for the protection of Resident #1 and Resident #3.</p> <p>A telephonic interview was conducted with the LPN (Staff #2) on January 9, 2024 at 8:04 AM. The LPN stated that she was a new nurse to that facility, and that she confirmed that she was the residents' assigned nurse on the night shift between January 3 and 4, 2024. She stated that she admitted Resident #3 into the facility that evening of January 3, 2024 at approximately 6:30 PM. She stated Resident #3 was confused and was looking for the bathroom. She stated that Resident #1 is hard to understand and that you really have to listen to what he is saying to understand him. She stated that Resident #1 kept coming out of his room saying that Resident #3 was coming into his room. She stated that she kept redirecting Resident #3 back to his own room, and Resident #1 continued to bang on the nurses' room door saying that Resident #3 was still coming to his room. She stated that at approximately 3:30 -3:40 AM, Resident #1 came out of his room pointing at his face and was saying he had been hit. She stated that when the CNA and herself got to Resident #1's room, they observed Resident #3 in the room. She stated that since she is a new nurse at the facility, that she asked the other nurse at the nurses' station what she should do in this situation since a resident is stating that he was hit in the face. She stated that the other nurse instructed her to call the ADON (Staff #31).</p> <p>(continued on next page)</p>		

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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>The interview continued and Staff #2 stated she placed a call to the ADON sometime between 3:35 and 3:45 AM. She stated the ADON did not answer, so a voicemail was left. Approximately sometime between 5:00 and 5:45 AM, she placed another call to the ADON, in which the ADON answered. Staff #2 stated that she told the ADON what had happened with the incident, and that the ADON responded and said that Resident #1 reacts to things like this. Staff #2 stated that the ADON then called someone else and Staff #2 was then speaking to a male's voice on the phone, whom she believed was the facility's Administrator. She stated that this person said that they didn't think this was an altercation. Staff #2 stated that she told the person on the phone that all night I was taking Resident #3 out of Resident #1's room. Further, Staff #2 stated that the ADON had told her not to document the incident in the medical record. Staff #2 told the ADON that she had written paper notes on the incident, and that the ADON had told her to hold on and wait for her guidance on what to write in the charts. Staff #2 stated that I didn't even leave that morning until 8:00 because I had a lady fall. She further stated that she felt overwhelmed that shift.</p> <p>The interview continued and Staff #2 stated that after Resident #1 had told her that he was hit in the face, that she believed he was afraid to lie back down in his bed to sleep because of Resident #3 who kept coming into his room. She stated that she sat with Resident #1 for a while in his room to help him calm down, and that every 30 minutes to an hour that she and the CNAs were checking on him. Staff #2 stated, in regard to her termination, that the ADON had fired her because the CNA's were saying that she was rude to them, and that she did not finish the admission for that night. She stated that the ADON had brought up that she did not report the allegation of abuse within the mandated timeframe, but that Staff #2 had told the ADON that she had first called her around 3:45 AM and that the incident had just happened about 5 minutes before that.</p> <p>Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed that Residents have the right to be free from abuse. The policy revealed that the facility will ensure adequate staffing and oversight to prevent burnout, stressful working situations, and high turnover rates. The facility will identify and investigate all possible incidents of abuse, and within timeframes required by federal requirements. Additionally, the facility will protect residents from any further harm during investigations.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on clinical record review, interviews, observations, facility documentation, and policies, the facility failed to implement written policies and procedures that prohibit and prevent abuse for 2 of 3 sampled residents (#1 and #3). The deficient practice could lead to a failure of the facility to fully investigate and report allegations of abuse within required timeframes, and could lead to harm to a resident.</p> <p>Findings Include:</p> <p>-Regarding Resident #1:</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis affecting the right side, aphasia, major depressive disorder, cerebral infarction, and chronic kidney disease.</p> <p>A physician order dated January 4, 2025, revealed a change in condition for: redness/ mild edema to left eye orbital, and that the provider was notified.</p> <p>A review of the resident's clinical record revealed no evidence of any progress notes on January 4, 2025, that described an incident involving Resident #1.</p> <p>There was no evidence of a physician order for one to one staff monitoring for Resident #1.</p> <p>A review of the facility's Incident Report Log revealed no evidence of any incident report for Resident #1 on January 4, 2025.</p> <p>A facility Reportable Incident Self-Report submitted to the state health department on January 4, 2025 at 10:06 AM, revealed that at approximately 9:00 a.m., on January 04, 2025, a nurse (Staff #14) notified the Administrator (Staff #55) and the Assistant Director of Nursing (ADON / Staff #31) that Resident #1 had slight redness to his eye. The report revealed that the resident is difficult to understand due to aphasia, however said something like "[NAME]" and was hitting/making hitting actions to his left eye. Further, the report revealed that we cannot tell if the redness in his left eye is from being struck by another resident or from Resident #1 hitting himself. The report revealed that an additional staff member has been placed to provide consistent observation between Resident #1 and his two roommates.</p> <p>There was no evidence of an update to the care plan for an incident occurring January 4, 2025.</p> <p>-Regarding Resident #3:</p> <p>Resident #3 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of brain, brief psychotic disorder, and acute kidney failure.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Health Status note dated January 4, 2025, at 2:56 PM, revealed that Resident #3 is on a change in condition for his new admission to the facility. Patient is alert and oriented x 4. Patient is able to make needs known verbally. There was no evidence in the note that the resident was on one to one staff monitoring.</p> <p>There was no evidence of progress notes dated January 4, 2025, documenting a resident to resident incident involving Resident #3.</p> <p>A Physician Progress Note dated January 4, 2025, signed by the Medical Director (Staff #18), revealed that Resident #3 has already been in physical confrontation apparently, and that Behavioral health will be consulted for his aggressive behavior and psychosis.</p> <p>A Health Status Note dated January 5, 2025, revealed that Resident #3 was on a change of condition for a resident to resident altercation. Resident was agitated and noncompliant with medication and vital signs. Resident has a one to one staff for monitoring. Resident has no physical or verbal aggression toward peers / staff this shift thus far.</p> <p>There was no evidence of a physician order for one to one staff monitoring.</p> <p>There was no evidence of a care plan update to address the resident's aggressive or combative behaviors.</p> <p>A formal request was made to the facility on [DATE], for any written statements from staff members or witnesses and any investigation interviews regarding the incident involving Resident #1 that occurred on January 4, 2025. The facility administrator signed a statement that the facility had none to date.</p> <p>However, despite this signed statement of having no written statements or interviews on January 8, the facility submitted a 5-day investigation report to the state health department on January 10, 2025. The investigation report revealed the following documented interviews:</p> <ul style="list-style-type: none"> -January 4, 2025: A phone interview between the Administrator and Resident #1 -January 4, 2025: An additional phone interview between the Administrator and Resident #1, where Resident #1 performed a hitting motion toward his eye and stating [NAME] [NAME]. -January 5, 2025: An interview between Resident #1 and staff where Resident #1 identified by pointing that Resident #3 was the individual that [NAME] [NAME] on him. -January 6, 2025: An additional interview between the Administrator and Resident #1. <p>Additional undated interviews included in the 5-day investigation report revealed:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The ADON (Staff #31) and Human Resources staff interviewed a Certified Nursing Assistant (CNA/ Staff #90), who was the assigned CNA during the shift of the alleged incident. Staff #90 stated that she did not witness the incident between the residents but overheard yelling and went to investigate. Resident #1 was outside of his room heading back to his room, and was stating repeated expletives, while making hitting motions toward his eye and stating [NAME], [NAME], [NAME]. Staff #90 asked if Resident #1 was hit and he shook his head, yes. She followed Resident #1 to his room and noticed that Resident #3 was sitting on Resident #1's bed. Staff #90 called on the radio for assistance from the nurse, and the nurse came. As both staff were getting Resident #3 back to his room, Resident #1 was pointing at Resident #3 and stating expletives and [NAME], [NAME]. The staff took statements from each resident after separating them to each of their rooms. Resident #1 stated he was struck by Resident #3. Resident #3 stated that Resident #1 kicked him in the balls 4 times.</p> <p>-The ADON and Human Resources staff interviewed a licensed practical nurse (LPN/ Staff #2) the assigned nurse to Resident #1 and Resident #3 on the night shift of the alleged incident, January 3 - 4, 2025. The interview revealed that the LPN stated that both residents are claiming the other struck them (that Resident #1 was struck in the eye by Resident #3, and that Resident #3 was kicked multiple times by Resident #1).</p> <p>-The Administrator interviewed an LPN (Staff #14), who stated she did not witness the event but that she saw Resident #1 had slight redness to his eye. Resident #1 kept telling her [NAME] and pointing or making a hitting motion to his eye.</p> <p>Additionally, the facility 5-day investigation report revealed that the redness on Resident #1's eye appears to be self-inflicted (from rubbing or touching it) rather from blunt force trauma (being struck by something).</p> <p>An Employee Coaching Form signed January 6, 2025, for the LPN (Staff #2) revealed that the nurse was being terminated. The nurse failed to complete admission requirements for a new resident and failed to report potential resident to resident altercation within the timeframe specified.</p> <p>An interview was conducted on January 8, 2025, at 10:11 AM, with a CNA (Staff #12), who stated that she was familiar with Resident #1, and that he is territorial with his belongings in his room and that he had an altercation with the new resident in his room. She stated that the night shift CNA (Staff #90) told her about the incident. Staff #12 stated that she had heard that the other resident hit Resident #1 in the eye. She stated that Resident #1 would not hit himself in the face.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on January 8, 2025, at 10:15 AM, with the CNA (Staff #90) who was assigned to the residents at the time of the incident. She stated she was in a nearby room providing care to another resident with the door open. She stated that she was not sure of the time, but that it was around 5:00 AM on January 4, 2025, that she heard Resident #1 coming out of his room yelling I hate you along with the expletive motherf****. Staff #90 stated that she went to see what was wrong, and that Resident #1 was slouched over in his wheelchair in the doorway of his room facing his bed. She stated that she observed Resident #3 in Resident #1's room, sitting on his bed, and wearing Resident #1's jacket and pants. She stated that she called on the radio for the nurse to come assist. She stated that Resident #1 was unresponsive at first, then appeared to regain consciousness. She stated that then the nurse arrived and that Resident #3 was redirected to his room. She stated that Resident #1 was gesturing to indicate that Resident #3 had hit him. She stated that Resident #3 admitted multiple times to hitting Resident #1 and that he further stated that he only hit him because he hit me in the balls. Staff #90 further stated that after the incident that shift, that Resident #1 was very agitated and angry afterward, that he kept bringing up the situation. After the incident, Staff #90 stated that the nurse had told her to make sure that the two residents don't talk to each other, but that Staff #90 then stated back to the nurse that she had to do her round assignments, and that the nurse left it at that. Staff #90 stated that she asked the nurses at the nurse's station what she should do, and that she was advised to make a written statement of the incident and to leave it in the cubby at the nurse's station. Staff #90 stated that a room change was not done, but that staff started a one-to-one monitoring of the residents the following morning shift.</p> <p>A telephonic interview was conducted with an LPN (Staff #14) on January 8, 2025 at 10:40 AM. Staff #14 stated that she arrived for her shift at approximately 6:00 AM on January 4, 2025, after the alleged incident involving Residents #1 and #3 had occurred. She stated that she was informed by the night nurse that there was an allegation that Resident #1 was hit by another resident. She stated that a little later in her shift, she noticed that Resident #1 had redness and swelling to his left eye. She stated that she followed up with the Director of Nursing and the Administrator to make sure that it was reported. She stated that she also notified the Medical Director. The LPN stated that the facility placed a one to one monitor on the residents as soon as we could on my shift.</p> <p>A telephonic interview was conducted on January 8, 2025, at 12:50 PM, with the facility's Medical Director and on-call physician (Staff #18). The Medical Director stated that he recalled being notified of the resident-to-resident physical altercation on January 4, 2025, and that it involved a potential head injury on Resident #1.</p> <p>A telephonic interview was conducted on January 8, 2025, at approximately 2:21 PM, with an LPN (Staff #28), who was the residents' assigned night shift nurse the following night after the incident. Staff #28 stated that I was told there was a resident-to-resident altercation and that Resident #1 was on a change of condition status. She additionally stated that he had bruising on the area of his eye, and that she noticed it the day after it happened.</p> <p>An observation was conducted on January 8, 2025, at 2:33 PM, of Resident #1 in his wheelchair in his room. Resident #1 consented to having the surveyor and a nurse observe his face. On the inside aspect of Resident #1's left eye, on the skin between his eye and his nose, was purple colored bruising. His right eye had no discoloration present.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Resident #1 at this time. When asked if the resident recalled getting into an incident with another resident, Resident #1 clearly stated yes, then some unintelligible words, and then [NAME], [NAME], [NAME], and motioned toward his face with his fist without making actual contact. When asked who did that?, Resident #1 pointed toward the room of where Resident #3 had resided.</p> <p>An interview was conducted with an LPN (Staff #40) on January 8, 2025, at 2:44 PM, who came to Resident #1's room together for an observation of the resident's face. Regarding the marking on the inside of Resident #1's left eye, Staff #40 stated that she saw discoloration and that she further described the color as diminished purple. Staff #40 stated that she was not sure what the discoloration was from because she was off of work for a few days, but that she knew he had a resident-to-resident altercation. She further stated that she believed the other resident involved in that incident was Resident #3.</p> <p>An interview was conducted on January 8, 2025, at 3:08 PM, with the ADON (Staff #31), who stated that if there is an allegation of abuse, that the facility staff is to respond by separating the two residents, and to report the allegation to the mandatory reporting agencies within a 2-hour window. The facility staff is to protect the residents either through increased supervision, or room changes, or through one to one staff monitoring. A skin assessment is done on the residents, and an incident report should be completed, along with a progress note describing the incident. She stated that if staff did not complete an incident report or document the incident in a progress note, that it would not meet her expectations. When reviewing the medical record of Resident #1 together, the ADON stated that she did not see any notes describing the resident to resident incident. She stated that in regard to the incident, that she did the interview with the nurse (Staff #2), and that there was an allegation of a resident-to-resident incident, but that she was not sure that it happened. She stated that the nurse did not report it to her within the mandatory 2-hour timeframe. She then stated that Staff #2 was terminated for failing to let the facility know of the alleged abuse timely.</p> <p>An interview was conducted on January 8, 2025, at 3:40 PM, with the Director of Nursing (DON/ Staff #63). The DON stated that the facility's process if there is an alleged abuse incident is for staff to notify the clinical managers, to notify the physician, notify the patient's guardian or power of attorney, to complete a risk management (incident report), to place any new orders from the physician, and to place the resident on a change of condition for 72-hour monitoring. The DON stated that the facility then investigates the incident by talking to residents and staff to see what happened, and that a progress note is completed, and a report made to the required reporting agencies. The facility protects the residents after an alleged abuse incident by placing the residents on one to one staff monitoring or providing a room change or by frequent monitoring. The DON further stated that her expectation is for staff to provide documentation in the clinical record of what they observed, to provide statements, to document any injuries, and what action was taken.</p> <p>The DON stated that regarding incident between Resident #1 and #3 on the night between January 3 and 4, 2025, that the Administrator had called her about a potential resident-to-resident allegation of abuse. She stated that we don't know if it truly happened, and that the night nurse did not report the incident within the 2 hours.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The clinical record of Resident #1 was reviewed together at that time with the DON. The DON stated that she did not see any progress note about the incident, and that it would not meet her expectation for documentation of an alleged incident. She additionally confirmed that a risk management (incident report) had not been completed. She stated that the night nurse was terminated for not reporting the incident timely. The DON stated that at approximately 10:27 AM after the incident was when she called the staffing coordinator to ensure that one-to-one monitoring was in place for the protection of Resident #1 and Resident #3.</p> <p>A telephonic interview was conducted with the LPN (Staff #2) on January 9, 2024 at 8:04 AM. The LPN stated that she was a new nurse to that facility, and that she confirmed that she was the residents' assigned nurse on the night shift between January 3 and 4, 2024. She stated that she admitted Resident #3 into the facility that evening of January 3, 2024 at approximately 6:30 PM. She stated Resident #3 was confused and was looking for the bathroom. She stated that Resident #1 is hard to understand and that you really have to listen to what he is saying to understand him. She stated that Resident #1 kept coming out of his room saying that Resident #3 was coming into his room. She stated that she kept redirecting Resident #3 back to his own room, and Resident #1 continued to bang on the nurses' room door saying that Resident #3 was still coming to his room. She stated that at approximately 3:30 -3:40 AM, Resident #1 came out of his room pointing at his face and was saying he had been hit. She stated that when the CNA and herself got to Resident #1's room, they observed Resident #3 in the room. She stated that since she is a new nurse at the facility, that she asked the other nurse at the nurses' station what she should do in this situation since a resident is stating that he was hit in the face. She stated that the other nurse instructed her to call the ADON (Staff #31).</p> <p>The interview continued and Staff #2 stated she placed a call to the ADON sometime between 3:35 and 3:45 AM. She stated the ADON did not answer, so a voicemail was left. Approximately sometime between 5:00 and 5:45 AM, she placed another call to the ADON, in which the ADON answered. Staff #2 stated that she told the ADON what had happened with the incident, and that the ADON responded and said that Resident #1 reacts to things like this. Staff #2 stated that the ADON then called someone else and Staff #2 was then speaking to a male's voice on the phone, whom she believed was the facility's Administrator. She stated that this person said that they didn't think this was an altercation. Staff #2 stated that she told the person on the phone that all night I was taking Resident #3 out of Resident #1's room. Further, Staff #2 stated that the ADON had told her not to document the incident in the medical record. Staff #2 told the ADON that she had written paper notes on the incident, and that the ADON had told her to hold on and wait for her guidance on what to write in the charts. Staff #2 stated that I didn't even leave that morning until 8:00 because I had a lady fall. She further stated that she felt overwhelmed that shift.</p> <p>The interview continued and Staff #2 stated that after Resident #1 had told her that he was hit in the face, that she believed he was afraid to lie back down in his bed to sleep because of Resident #3 who kept coming into his room. She stated that she sat with Resident #1 for a while in his room to help him calm down, and that every 30 minutes to an hour that she and the CNAs were checking on him. Staff #2 stated, in regard to her termination, that the ADON had fired her because the CNA's were saying that she was rude to them, and that she did not finish the admission for that night. She stated that the ADON had brought up that she did not report the allegation of abuse within the mandated timeframe, but that Staff #2 had told the ADON that she had first called her around 3:45 AM and that the incident had just happened about 5 minutes before that.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed that Residents have the right to be free from abuse. The policy revealed that the facility will ensure adequate staffing and oversight to prevent burnout, stressful working situations, and high turnover rates. The facility will identify and investigate all possible incidents of abuse, and within timeframes required by federal requirements. Additionally, the facility will protect residents from any further harm during investigations.</p> <p>Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised April 2021, revealed that if resident abuse or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as two hours in any allegation involving abuse. Upon receiving any allegation of abuse, the administrator is responsible for determining what actions are needed for the protection of residents. All allegations are thoroughly investigated. The individual conducting the investigation as a minimum: reviews the documentation and evidence, observes the alleged victim, interviews the person reporting the incident and any witnesses, and the residents, and documents the investigation completely and thoroughly. The administrator or designee provide the appropriate agencies of the findings of the investigation within five working days of the occurrence of the incident.</p> <p>Review of the facility's policy titled Accidents and Incidents - Investigating and Reporting, revised July 2017, revealed that all incidents involving residents will be investigated and reported to the Administrator. The Nurse Supervisor/Charge Nurse and/or department supervisor will promptly initiate and document investigation of the incident, and complete a Risk Management/ Report of Incident.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on clinical record review, interviews, observations, facility documentation, and policies, the facility failed to ensure that an allegation of abuse was reported to mandatory reporting agencies within the required timeframe for 2 of 3 sampled residents (#1 and #3). The deficient practice could result in abuse allegation not being reported.</p> <p>Findings Include:</p> <p>-Regarding Resident #1:</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis affecting the right side, aphasia, major depressive disorder, cerebral infarction, and chronic kidney disease.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.</p> <p>A facility Reportable Incident Self-Report submitted to the state health department on January 4, 2025 at 10:06 AM, revealed that at approximately 9:00 a.m., on January 04, 2025, a nurse (Staff #14) notified the Administrator (Staff #55) and the Assistant Director of Nursing (ADON / Staff #31) that Resident #1 had slight redness to his eye. The report revealed that the resident is difficult to understand due to aphasia, however said something like 'pow' and was hitting/making hitting actions to his left eye. Further, the report revealed that we cannot tell if the redness in his left eye is from being struck by another resident or from Resident #1 hitting himself.</p> <p>-Regarding Resident #3:</p> <p>Resident #3 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of brain, brief psychotic disorder, and acute kidney failure.</p> <p>A Health Status Note dated January 5, 2025, revealed that Resident #3 was on a change of condition for a resident to resident altercation. Resident was agitated and noncompliant with medication and vital signs. Resident has a one to one staff for monitoring. Resident has no physical or verbal aggression toward peers / staff this shift thus far.</p> <p>An Employee Coaching Form signed January 6, 2025, for a licensed practical nurse (LPN / Staff #2) revealed that the nurse was being terminated. The nurse failed to complete admission requirements for a new resident and failed to report potential resident to resident altercation within the timeframe specified.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on January 8, 2025, at 10:15 AM, with a certified nursing assistant (CNA / Staff #90) who was assigned to the residents at the time of the incident. She stated she was in a nearby room providing care to another resident with the door open. She stated that she was not sure of the time, but that it was around 5:00 AM on January 4, 2025, that she heard Resident #1 coming out of his room yelling I hate you along with the expletive motherf****. Staff #90 stated that she went to see what was wrong, and that Resident #1 was slouched over in his wheelchair in the doorway of his room facing his bed. She stated that she observed Resident #3 in Resident #1's room, sitting on his bed, and wearing Resident #1's jacket and pants. She stated that she called on the radio for the nurse to come assist. She stated that Resident #1 was unresponsive at first, then appeared to regain consciousness. She stated that then the nurse arrived and that Resident #3 was redirected to his room. She stated that Resident #1 was gesturing to indicate that Resident #3 had hit him. She stated that Resident #3 admitted multiple times to hitting Resident #1 and that he further stated that he only hit him because he hit me in the balls.</p> <p>An interview was conducted on January 8, 2025, at 3:08 PM, with the ADON (Staff #31), who stated that if there is an allegation of abuse, that the facility staff is to respond by separating the two residents, and to report the allegation to the mandatory reporting agencies within a 2-hour window. She stated that in regard to the incident, that she did the interview with the nurse (Staff #2), and that there was an allegation of a resident-to-resident incident, but that she was not sure that it happened. She stated that the nurse did not report it to her within the mandatory 2-hour timeframe. She then stated that Staff #2 was terminated for failing to let the facility know of the alleged abuse timely.</p> <p>An interview was conducted on January 8, 2025, at 3:40 PM, with the Director of Nursing (DON/ Staff #63). The DON stated that the facility's process if there is an alleged abuse incident is for staff to notify the clinical managers, to notify the physician, notify the patient's guardian or power of attorney, to complete a risk management (incident report), to place any new orders from the physician, and a report is made to the required reporting agencies. The DON stated that regarding incident between Resident #1 and #3 on the night between January 3 and 4, 2025, that the Administrator had called her about a potential resident-to-resident allegation of abuse. She stated that we don't know if it truly happened, and that the night nurse did not report the incident within the 2 hours.</p> <p>A telephonic interview was conducted with the LPN (Staff #2) on January 9, 2024 at 8:04 AM. The LPN stated that she was a new nurse to that facility, and that she confirmed that she was the residents' assigned nurse on the night shift between January 3 and 4, 2024. She stated that she admitted Resident #3 into the facility that evening of January 3, 2024 at approximately 6:30 PM She stated that at approximately 3:30 -3:40 AM, Resident #1 came out of his room pointing at his face and was saying he had been hit. She stated that another nurse instructed her to call the ADON (Staff #31). Staff #2 stated she placed a call to the ADON sometime between 3:35 and 3:45 AM. She stated the ADON did not answer, so a voicemail was left. Approximately sometime between 5:00 and 5:45 AM, she placed another call to the ADON, in which the ADON answered. Staff #2 stated that she told the ADON what had happened with the incident. Staff #2 stated that I didn't even leave that morning until 8:00 because I had a lady fall. She further stated that she felt overwhelmed that shift. She stated that the ADON had brought up that she did not report the allegation of abuse within the mandated timeframe, but that Staff #2 had told the ADON that she had first called her around 3:45 AM and that the incident had just happened about 5 minutes before that.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised April 2021, revealed that all reports of resident abuse are reported to local, state, and federal agencies (as required by current regulations). The administrator or the individual making the allegation reports to the state licensing agency immediately, which is defined as within 2 hours for allegations involving abuse.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on clinical record review, interviews, observations, facility documentation, and policies, the facility failed to ensure that residents were protected from further abuse during an ongoing investigation of an allegation of abuse for 2 of 3 sampled residents (#1 and #3). The deficient practice could result in continued psychosocial and/or physical harm to a resident.</p> <p>Findings Include:</p> <p>-Regarding Resident #1:</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis affecting the right side, aphasia, major depressive disorder, cerebral infarction, and chronic kidney disease.</p> <p>A review of the resident's clinical record revealed no evidence of any progress notes on January 4, 2025, that described an incident involving Resident #1.</p> <p>There was no evidence of a physician order for one to one staff monitoring for Resident #1.</p> <p>A facility Reportable Incident Self-Report submitted to the state health department on January 4, 2025 at 10:06 AM, revealed that at approximately 9:00 a.m., on January 04, 2025, a nurse (Staff #14) notified the Administrator (Staff #55) and the Assistant Director of Nursing (ADON / Staff #31) that Resident #1 had slight redness to his eye. The report revealed that the resident is difficult to understand due to aphasia, however said something like 'pow' and was hitting/making hitting actions to his left eye. Further, the report revealed that we cannot tell if the redness in his left eye is from being struck by another resident or from Resident #1 hitting himself. The report revealed that an additional staff member has been placed to provide consistent observation between Resident #1 and his two roommates.</p> <p>A care plan, revised April 04, 2024, revealed that Resident #1 has a behavioral problem and can demonstrate physical aggression toward others, with resident-to-resident incidents listed on June 6 and June 18, 2023. Interventions included intervene as necessary to protect the rights and safety of others, and to document behavior and possible causes. There was no evidence of an update to the care plan for an incident occurring January 4, 2025.</p> <p>-Regarding Resident #3:</p> <p>Resident #3 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of brain, brief psychotic disorder, and acute kidney failure.</p> <p>A Health Status note dated January 4, 2025, at 2:56 PM, revealed that Resident #3 is on a change in condition for his new admission to the facility. Patient is alert and oriented x 4. Patient is able to make needs known verbally. There was no evidence in the note that the resident was on one to one staff monitoring.</p> <p>(continued on next page)</p>		

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 01/08/2025
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.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no evidence of progress notes dated January 4, 2025, documenting a resident to resident incident involving Resident #3.</p> <p>A Physician Progress Note dated January 4, 2025, signed by the Medical Director (Staff #18), revealed that Resident #3 has already been in physical confrontation apparently, and that Behavioral health will be consulted for his aggressive behavior and psychosis.</p> <p>There was no evidence of a physician order for one to one staff monitoring.</p> <p>The resident's baseline care plan, signed January 8, 2025, revealed an initial goal for coping skills and adjustments to situations and new environments, with an intervention to refer to psychiatrist/Psychologist as indicated. There was no evidence of a care plan update to address the resident's aggressive or combative behaviors.</p> <p>An interview was conducted on January 8, 2025, at 10:15 AM, with the certified nursing assistant (CNA / Staff #90) who was assigned to the residents at the time of the incident. She stated she was in a nearby room providing care to another resident with the door open. She stated that she was not sure of the time, but that it was around 5:00 AM on January 4, 2025, that she heard Resident #1 coming out of his room yelling I hate you along with the expletive motherf*****. Staff #90 stated that she went to see what was wrong, and that Resident #1 was slouched over in his wheelchair in the doorway of his room facing his bed. She stated that she observed Resident #3 in Resident #1's room, sitting on his bed, and wearing Resident #1's jacket and pants. She stated that she called on the radio for the nurse to come assist. She stated that Resident #1 was unresponsive at first, then appeared to regain consciousness. She stated that then the nurse arrived and that Resident #3 was redirected to his room. She stated that Resident #1 was gesturing to indicate that Resident #3 had hit him. She stated that Resident #3 admitted multiple times to hitting Resident #1 and that he further stated that he only hit him because he hit me in the balls. Staff #90 further stated that after the incident that shift, that Resident #1 was very agitated and angry afterward, that he kept bringing up the situation. After the incident, Staff #90 stated that the nurse had told her to make sure that the two residents don't talk to each other, but that Staff #90 then stated back to the nurse that she had to do her round assignments, and that the nurse left it at that. Staff #90 stated that she asked the nurses at the nurse's station what she should do, and that she was advised to make a written statement of the incident and to leave it in the cubby at the nurse's station. Staff #90 stated that a room change was not done, but that staff started a one-to-one monitoring of the residents the following morning shift.</p> <p>A telephonic interview was conducted with a licensed practical nurse (LPN / Staff #14) on January 8, 2025 at 10:40 AM. Staff #14 stated that she arrived for her shift at approximately 6:00 AM on January 4, 2025, after the alleged incident involving Residents #1 and #3 had occurred. She stated that she was informed by the night nurse that there was an allegation that Resident #1 was hit by another resident. The LPN stated that the facility placed a one to one staff monitor on the residents as soon as we could on my shift.</p> <p>An interview was conducted on January 8, 2025, at 3:08 PM, with the ADON (Staff #31), who stated that if there is an allegation of abuse, that the facility staff is to respond by separating the two residents, and the facility staff is to protect the residents either through increased supervision, or room changes, or through one to one staff monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on January 8, 2025, at 3:40 PM, with the Director of Nursing (DON/ Staff #63). The DON stated that the facility's process if there is an alleged abuse incident is that the facility protects the residents after an alleged abuse incident by placing the residents on one to one staff monitoring or providing a room change or by frequent monitoring. The clinical record of Resident #1 was reviewed together at that time with the DON. She additionally confirmed that a risk management (incident report) had not been completed. She stated that the night nurse was terminated for not reporting the incident timely. The DON stated that on January 4, 2025, at approximately 10:27 AM, after the incident was when she called the staffing coordinator to ensure that one-to-one monitoring was in place for the protection of Resident #1 and Resident #3.</p> <p>A telephonic interview was conducted with the LPN (Staff #2) on January 9, 2024 at 8:04 AM. The LPN stated that she was a new nurse to that facility, and that she confirmed that she was the residents' assigned nurse on the night shift between January 3 and 4, 2024. She stated Resident #3 was confused and was looking for the bathroom. She stated that Resident #1 is hard to understand and that you really have to listen to what he is saying to understand him. She stated that Resident #1 kept coming out of his room saying that Resident #3 was coming into his room. She stated that she kept redirecting Resident #3 back to his own room, and Resident #1 continued to bang on the nurses' room door saying that Resident #3 was still coming to his room. She stated that at approximately 3:30 -3:40 AM, Resident #1 came out of his room pointing at his face and was saying he had been hit. She stated that when the CNA and herself got to Resident #1's room, they observed Resident #3 in the room.</p> <p>The interview continued and Staff #2 stated that after Resident #1 had told her that he was hit in the face, that she believed he was afraid to lie back down in his bed to sleep because of Resident #3 who kept coming into his room. She stated that she sat with Resident #1 for a while in his room to help him calm down, and that every 30 minutes to an hour that she and the CNAs were checking on him, but that the two residents were still sharing a room area.</p> <p>Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed that the facility will protect residents from any further harm during investigations.</p>		