STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035247	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Gardens Post Acute	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#1) was free from abuse. The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Regarding resident #1: Resident was admitted to the facility on [DATE] with diagnosis that included intracerebral hemorrhage, unspecified, flaccid hemiplegia affecting left dominant side, major depressive disorder, single episode, unspecified, anxiety disorder, unspecified, unspecified mood [affective] disorder. A review of the quarterly MDS (minimum data set) dated December 23, 2024 revealed a BIMS (brief interview of mental status) score of 14, indicating resident's cognition is intact. Further review of the MDS revealed no indicators for mood or behaviors. A review of the resident's care plan, initiated on December 23, 2024 revealed a focus for impaired cognitive function/impaired thought processes related to impaired decision making, neurological symptoms. Interventions included to administer medications as ordered. Further review of the care plan revealed a focus for psychosocial behaviors related to physically and verbally sexual inappropriateness. Interventions included intervening as necessary to protect the rights and safety of others and to monitor behaviors episodes and attempt to determine underlying cause. A review of the progress notes revealed an alert charting entry dated January 19, 2025 that at approximately 04:30am Certified Nursing Assistant (CNA) called nurse to room to find patient with hematoma to left above eye about golf size. According to resident, roommate had beam rummaging through his closet and taking his clothes. When approached about leaving his clothing alone resident was allegedly hit with a water pitcher by the roommate who allegedly threw it at him. Nurses assisted with wound dressing to bleeding hematoma at the time. The progress note stated notifications to administration, Director of Nursing (DON), case worker, and family all completed. The note stated police were also called and resident was sent to emergency room . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes revealed an entry dated January 19, 2025 that stated resident #1 returned from the hospital with no new orders. The resident was observed to have knots around the left side of forehead that had two steri-strips. The progress note stated the report from emergency room nurse from the hospital stated the CT scan was negative. -Regarding resident #2: Resident #2 was admitted on [DATE] with diagnosis that included other acute osteomyelitis, left ankle and foot, major depressive disorder, recurrent, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the Medicare 5-day MDS dated [DATE] revealed a BIMS (brief interview of mental status) score of 7 indicating severe cognitive impairment. Further review of the MDS revealed a severity score of 7 for mood and delusional behaviors. A review of the resident's care plan, date-initiated on January 15, 2025 revealed a focus for psychosocial behaviors; related to psych diagnosis; monitoring for agitation and sad mood. Interventions included to intervene as necessary to protect the rights and safety of others and approach/speak in a calm manner, divert attention and remove from the situation and take to an alternate location as needed. Review of the progress notes revealed an alert note entry dated January 19, 2025 that resident was allegedly involved in an altercation with his roommate. The progress note stated resident #2 threw a water pitcher at his roommate. Review of the progress notes revealed a health status note dated January 21, 2025 that resident is on change of condition for resident to resident altercation. The progress noted stated no increased agitation noted or reported. It further stated no physical or verbal aggression or roommate conflict. A request was made for the facility self-report or any documentation from the investigation on January 23, 2025 at 11:50 a.m. Staff #320 replied in writing on January 23, 2025 at 12:35 p.m. Our investigation is still in progress, report currently not available. An interview was conducted on January 23, 2025 at 2:03p.m. with resident #1. During the interview it was observed that resident #1 had a hematoma with a small cut in the center on the left side of the resident forehead. Also noted a laceration approximately one inch in length on the left top of the resident's head and purple and blue bruising to the left corner of the resident's eye. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with Resident #1, resident #1 stated the incident occurred between 2:00a.m and 5:00a.m. Resident #1 stated resident #2 was removing clothing from resident #1's closet. Resident #1 stated he got out of bed and went to the bathroom and when he returned resident #2 had put resident #1's pants on and was also attempting to put on one his shirts. Resident #1 stated he tried to grab his shirt and this is when resident #2 grabbed a plastic water pitcher filled with water and clonked me on the head 2-4 times. Resident #1 stated he yelled for his roommate, resident #4 to call for the nurse. Resident #1 stated a nurse came in and asked what was going on. Resident #1 stated he told the nurse resident #2 was taking his clothing from his closet and she turned around and left. Resident #1 could not recall the name of the nurse or provide any identifiers. Resident #1 stated CNA #5 entered the room because the call light was still on and saw the bleeding from his forehead and went for a nurse who treated the wound and sent the resident to the hospital for a CT scan. Resident #1 stated nursing staff were aware of prior incidents of resident #2 taking his clothing. An attempt to interview resident #2 was conducted on January 23, 2025 at 2: 03 p.m. resident was observed on sitting on the patio talking to himself and grasping at the air. Due to the resident's cognition the interview was unable to be completed. An interview was conducted on January 23, 2025 at 2: 15p.m with resident #4. Resident #4 stated resident #2 would often take his food and water from his bedside table. Resident #4 stated he observed the altercation between resident #1 and #2. Resident #4 stated he observed resident #2 swing the cup that holds the water, raising it above his head swinging at resident #1 head. Resident #4 stated Resident #2 hit resident #1 in the head and then swung again hitting him on the head again. Resident #4 stated resident #1 called for him stating help me. Resident #4 stated he was too slow to help as he was in bed before he was able to get to him. Resident #4 stated as he was walking toward resident #1 he observed resident #2 jab resident #1 with his walker. Resident #4 stated I saw a hole on resident #1 head and blood streaming down his head and neck. Resident #4 stated he turned on the call light and two nursing staff came in. Resident #4 stated he informed the nursing staff what had happened. Resident #4 stated his bed is located directly in front of resident #1. Resident #4 stated every night it was something with resident #2 and resident #2 was always in resident #1 closet going through his clothing and trying to wear them. Attempt to contact CNA/Staff #5 was conducted on January 23, 2025 at 2:12 p.m. Message left for a return phone call. An interview was conducted on January 23, 2025 at 2:21 p.m. with CNA/Staff #9. Staff # 9 stated she has worked with both resident #1 and #2. Staff #9 stated resident #2 had a recent room change due to an incident with resident #1. Staff #9 stated she had heard that resident #2 had went up to resident #1 and hit him with a cup. Staff #9 stated she has not observed any aggressive behaviors from resident #2, but that he can be non-compliant with care. Staff #9 stated when there is an incident involving residents that the expectation is that the residents are placed on 1:1 supervision with an immediate room change. Staff #9 stated she has received abuse training and has been trained that staff are to separate the residents involved, report immediately, monitor the situation and take the victim away and out of the situation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 23, 2025 at 2: 03p.m with Licensed Practical Nurse LPN/Staff #7. Staff #7 stated if staff are made aware of an altercation between residents they are to immediately separate, look for injuries, follow the reporting process, notifying the administrator. Staff #7 stated she was informed through report that resident #1 had injuries from an altercation with resident #2 Staff #7 stated there were no reported injuries with resident #2. Staff #7 stated resident #1 is on behavior monitoring for medications and has not received any reports for non-compliance with care. Staff #7 stated there have been no prior incidents with residents #1 or #2. An interview was conducted on January 23, 2025 at 2:55 p.m. with Director of Nursing DON/Staff #30. The DON stated she received a call from Assistant Director of Nursing/ADON/Staff #42 the morning of January 20 at 4:42am informing her that there was an alleged resident to resident altercation and that resident # 2 had thrown a water pitcher at resident #1. Staff #30 stated when she interviewed resident #1 he had informed her that resident #2 was in his closet and when he had told him to get out of his closet that resident #2 had thrown the water pitcher at him. Staff #30 stated the process for reporting alleged abuse is to contact the abuse coordinator, the DON, ADON, other state agencies, family and provider. Staff #30 stated resident both residents were assessed for potential injuries with a skin check and that resident #1 was sent to the hospital due to a hematoma on his head it was bleeding at the time. Staff #30 stated a CT was conducted at the hospital revealing no findings or new orders. A review was conducted of Point Click Care (PCC) , the facility data base for residents by staff #30 revealing no skin assessment completed at the time of injury or following. Further review by Staff #30 revealed no documentation of the laceration on the top L side of resident #1 head. Staff #30 stated she was unaware of the laceration. Staff #30 stated it is her expectation that a skin evaluation and change of condition be completed. Staff #30 stated the risks of not completing the skin assessment can lead to reports of injuries of unknown origin, leading to a delay in treatment and care of the resident. Staff #30 further stated the progress notes of the resident to resident incident is not detailed or thorough and the risks associated with this is missing key information in how to treat or care for the resident when you don't provide accurate documentation. Staff # 30 stated the facility did not have a final hospital report, but would request one. Further review of PCC by staff #30 revealed no documentation for the 1:1 provided for resident #2 or the room change. An interview was conducted on January 23, 2025 at 3:59 p.m. with CNA /Staff #5. Sattf #5 stated she was working the night shift on January 20, 2025 when she noticed the call light on in residents #1, #4 and #2 room. Staff #5 stated when she entered the room she noticed water and shaving cream on the floor. Staff # 5 stated resident #1 was in the bathroom and when he came out she noticed his head and forehead were bleeding. Staff #5 stated resident #2 was sitting on his bed dressed head to toe in resident #1's clothing. Staff #5 stated she immediately went to get the nurse. Staff #5 resident #1 was found to have a knot to the left side of his forehead near his eye and a cut on left top of his head. Staff #5 stated resident #1 informed her and the registry nurse that resident #2 had hit him on top of the head with the water pitcher. Staff #5 stated the nurse addressed resident #1's injuries and that she helped change resident #2 clothing which was wet with water and shaving cream. Staff #5 stated she took resident #2 to the dining room, providing him 1:1 supervision until the day shift arrived. Staff #5 stated resident #1 was sent to the hospital. Staff #5 stated resident #1 had previously informed her that resident #2 would go into other residents' closets and wander around, but no prior incidents of abuse. Staff #5 stated she did not report the information. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 23, 2025 at 4:39 p.m. with Abuse Coordinator/ Administrator /Staff # 20. Staff #20 stated he was notified of the alleged abuse at approximately 4:30 am on January 20, 2025. It was reported that resident #2 was confused and had gone through resident #1's things and when asked to stop, resident #2 tossed the cup or mug at him. Staff #20 stated the residents were immediately separated and contacted the provider. The provider asked that resident #1 be sent to the hospital to be evaluated. Staff had reported resident #1 had a cut above his eye. Staff #20 stated resident #2 was separated from all residents and monitored by staff. Staff #20 stated resident #2 was moved to anther room once resident #1 was sent to the hospital. Staff #20 stated interviews were conducted with the other roommates who were available. Staff #20 stated the investigation is ongoing, but does not feel that there was malicious intent. Staff #20 stated resident #2 was moved to another room the same morning. The request for hospital records were provided on January 23, 2025 at 4:42 p.m. The admission physical assessment revealed resident #1 had 2 small hematomas on the frontal aspect and parietal aspect with overlying small lacerations that were closed with steri-strips. Further review of the hospital report revealed resident #1 informed hospital staff that he wanted to press charges and that security was notified to have a police report made. A review of the facility policy titled Abuse Prevention Program revised August 2006 states our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on observation, staff interviews, clinical record review and facility documentation and policy review, the facility failed to ensure accurate documentation for one resident's injuries (#1). This deficient practice could result in residents not receiving the necessary treatment to address their medical issues/problems. Findings include: -Regarding resident #1: Resident was admitted to the facility on [DATE] with diagnosis that included intracerebral hemorrhage, unspecified, flaccid hemiplegia affecting left dominant side, major depressive disorder, single episode, unspecified, anxiety disorder, unspecified, unspecified mood [affective] disorder. A review of the quarterly MDS (minimum data set) dated December 23, 2024 revealed a BIMS (brief interview of mental status) score of 14, indicating resident's cognition is intact. Further review of the MDS revealed no indicators for mood or behaviors. A review of the resident's care plan, initiated on December 23, 2024 revealed a focus for impaired cognitive function/impaired thought processes related to impaired decision making, neurological symptoms. Interventions included to administer medications as ordered. Further review of the care plan revealed a focus for psychosocial behaviors related to physically and verbally sexual inappropriateness. Interventions included intervening as necessary to protect the rights and safety of others and to monitor behaviors episodes and attempt to determine underlying cause. A review of the progress notes revealed an alert charting entry dated January 19, 2025 that at approximately 04:30am Certified Nursing Assistant (CNA) called nurse to room to find patient with hematoma to left above eye about golf size. According to resident, roommate had beam rummaging through his closet and taking his clothes. When approached about leaving his clothing alone resident was allegedly hit with a water pitcher by the roommate who allegedly threw it at him. Nurses assisted with wound dressing to bleeding hematoma at the time. The progress note stated notifications to administration, Director of Nursing (DON), case worker, and family all completed. The note stated police were also called and resident was sent to emergency room . Review of the progress notes revealed an entry dated January 19, 2025 that stated resident #1 returned from the hospital with no new orders. The resident was observed to have knots around the left side of forehead that had two steri-strips. The progress note stated the report from emergency room nurse from the hospital stated the CT scan was negative. -Regarding resident #2: Resident #2 was admitted on [DATE] with diagnosis that included other acute osteomyelitis, left ankle and foot, major depressive disorder, recurrent, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medicare 5-day MDS dated [DATE] revealed a BIMS (brief interview of mental status) score of 7 indicating severe cognitive impairment. Further review of the MDS revealed a severity score of 7 for mood and delusional behaviors. A review of the resident's care plan, date-initiated on January 15, 2025 revealed a focus for psychosocial behaviors; related to psych diagnosis; monitoring for agitation and sad mood. Interventions included to intervene as necessary to protect the rights and safety of others and approach/speak in a calm manner, divert attention and remove from the situation and take to an alternate location as needed. Review of the progress notes revealed an alert note entry dated January 19, 2025 that resident was allegedly involved in an altercation with his roommate. The progress note stated resident #2 threw a water pitcher at his roommate. Review of the progress notes revealed a health status note dated January 21, 2025 that resident is on change of condition for resident to resident altercation. The progress noted stated no increased agitation noted or reported. It further stated no physical or verbal aggression or roommate conflict. A request was made for the facility self-report or any documentation from the investigation on January 23, 2025 at 11:50 a.m. Staff #320 replied in writing on January 23, 2025 at 12:35 p.m. Our investigation is still in progress, report currently not available. An interview was conducted on January 23, 2025 at 2:03p.m. with resident #1. During the interview it was observed that resident #1 had a hematoma with a small cut in the center on the left side of the resident forehead. Also noted a laceration approximately one inch in length on the left top of the resident's head and purple and blue bruising to the left corner of the resident's eye. During the interview with Resident #1, resident #1 stated the incident occurred between 2:00a.m and 5:00a.m. Resident #1 stated resident #2 was removing clothing from resident #1's closet. Resident #1 stated he got out of bed and went to the bathroom and when he returned resident #2 had put resident #1's pants on and was also attempting to put on one his shirts. Resident #1 stated he tried to grab his shirt and this is when resident #2 grabbed a plastic water pitcher filled with water and clonked me on the head 2-4 times. Resident #1 stated he yelled for his roommate, resident #4 to call for the nurse. Resident #1 stated a nurse came in and asked what was going on. Resident #1 stated he told the nurse resident #2 was taking his clothing from his closet and she turned around and left. Resident #1 could not recall the name of the nurse or provide any identifiers. Resident #1 stated CNA #5 entered the room because the call light was still on and saw the bleeding from his forehead and went for a nurse who treated the wound and sent the resident to the hospital for a CT scan. Resident #1 stated nursing staff were aware of prior incidents of resident #2 taking his clothing. An attempt to interview resident #2 was conducted on January 23, 2025 at 2: 03 p.m. resident was observed on sitting on the patio talking to himself and grasping at the air. Due to the resident's cognition the interview was unable to be completed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 23, 2025 at 2: 15p.m with resident #4. Resident #4 stated resident #2 would often take his food and water from his bedside table. Resident #4 stated he observed the altercation between resident #1 and #2. Resident #4 stated he observed resident #2 swing the cup that holds the water, raising it above his head swinging at resident #1 head. Resident #4 stated Resident #2 hit resident #1 in the head and then swung again hitting him on the head again. Resident #4 stated resident #1 called for him stating help me. Resident #4 stated he was too slow to help as he was in bed before he was able to get to him. Resident #4 stated as he was walking toward resident #1 he observed resident #2 jab resident #1 with his walker. Resident #4 stated I saw a hole on resident #1 head and blood streaming down his head and neck. Resident #4 stated he turned on the call light and two nursing staff came in. Resident #4 stated he informed the nursing staff what had happened. Resident #4 stated his bed is located directly in front of resident #1. Resident #4 stated every night it was something with resident #2 and resident #2 was always in resident #1 closet going through his clothing and trying to wear them. Attempt to contact CNA/Staff #5 was conducted on January 23, 2025 at 2:12 p.m. Message left for a return phone call. An interview was conducted on January 23, 2025 at 2:21 p.m. with CNA/Staff #9. Staff # 9 stated she has worked with both resident #1 and #2. Staff #9 stated resident #2 had a recent room change due to an incident with resident #1. Staff #9 stated she had heard that resident #2 had went up to resident #1 and hit him with a cup. Staff #9 stated she has not observed any aggressive behaviors from resident #2, but said that he can be non-compliant with care. Staff #9 stated when there is an incident involving residents that the expectation is that the residents are placed on 1:1 supervision with an immediate room change. Staff #9 stated she has received abuse training and has been trained that staff are to separate the residents involved, report immediately, monitor the situation and take the victim away and out of the situation. An interview was conducted on January 23, 2025 at 2: 03p.m with Licensed Practical Nurse LPN/Staff #7. Staff #7 stated if staff are made aware of an altercation between residents they are to immediately separate, look for injuries, follow the reporting process, notifying the administrator. Staff #7 stated she was informed through report that resident #1 had injuries from an altercation with resident #2. Staff #7 stated there were no reported injuries with resident #2. Staff #7 stated resident #1 is on behavior monitoring for medications and has not received any reports for non-compliance with care. Staff #7 stated there have been no prior incidents with residents #1 or #2. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 23, 2025 at 2:55 p.m. with Director of Nursing DON/Staff #30. The DON stated she received a call from Assistant Director of Nursing/ADON/Staff #42 the morning of January 20 at 4:42am informing her that there was an alleged resident to resident altercation and that resident # 2 had thrown a water pitcher at resident #1. Staff #30 stated when she interviewed resident #1 he had informed her that resident #2 was in his closet and when he had told him to get out of his closet that resident #2 had thrown the water pitcher at him. Staff #30 stated the process for reporting alleged abuse is to contact the abuse coordinator, the DON, ADON, other state agencies, family and provider. Staff #30 stated both residents were assessed for potential injuries with a skin check and that resident #1 was sent to the hospital due to a hematoma on his head it was bleeding at the time. Staff #30 stated a CT was conducted at the hospital revealing no findings or new orders. A review was conducted of Point Click Care (PCC) , the facility data base for residents by staff #30 revealing no skin assessment completed at the time of injury or following. Further review by Staff #30 revealed no documentation of the laceration on the top L side of resident #1's head. Staff #30 stated she was unaware of the laceration. Staff #30 stated it is her expectation that a skin evaluation and change of condition be completed. Staff #30 stated the risks of not completing the skin assessment can lead to reports of injuries of unknown origin, leading to a delay in treatment and care of the resident. Staff #30 further stated the progress notes of the resident to resident incident is not detailed or thorough and the risks associated with this is missing key information in how to treat or care for the resident when you don't provide accurate documentation. Staff # 30 stated the facility did not have a final hospital report, but would request one. Further review of PCC by staff 30 revealed no documentation for the 1:1 provided for resident #2 or the room change. An interview was conducted on January 23, 2025 at 3:59 p.m. with CNA /Staff #5. Sattf #5 stated she was working the night shift on January 20, 2025 when she noticed the call light on in residents #1, #4 and #2 room. Staff #5 stated when she entered the room she noticed water and shaving cream on the floor. Staff # 5 stated resident #1 was in the bathroom and when he came out she noticed his head and forehead were bleeding. Staff #5 stated resident #2 was sitting on his bed dressed head to toe in resident #1's clothing. Staff #5 stated she immediately went to get the nurse. Staff #5 resident #1 was found to have a knot to the left side of his forehead near his eye and a cut on left top of his head. Staff #5 stated resident #1 informed her and the registry nurse that resident #2 had hit him on top of the head with the water pitcher. Staff #5 stated the nurse addressed resident #1's injuries and that she helped change resident #2 clothing which was wet with water and shaving cream. Staff #5 stated she took resident #2 to the dining room, providing him 1:1 supervision until the day shift arrived. Staff #5 stated resident #1 was sent to the hospital. Staff #5 stated resident #1 had previously informed her that resident #2 would go into other residents' closets and wander around, but no prior incidents of abuse. Staff #5 stated she did not report the information. An interview was conducted on January 23, 2025 at 4:39 p.m. with Abuse Coordinator/ Administrator /Staff # 20. Staff #20 stated he was notified of the alleged abuse at approximately 4:30 am on January 20, 2025. It was reported that resident #2 was confused and had gone through resident #1's things and when asked to stop, resident #2 tossed the cup or mug at him. Staff #20 stated the residents were immediately separated and contacted the provider. The provider asked that resident #1 be sent to the hospital to be evaluated. Staff had reported resident #1 had a cut above his eye. Staff #20 stated resident #2 was separated from all residents and monitored by staff. Staff #20 stated resident #2 was moved to anther room once resident #1 was sent to the hospital. Staff #20 stated interviews were conducted with the other roommates who were available. Staff #20 stated the investigation is ongoing, but does not feel that there was malicious intent. Staff #20 stated resident #2 was moved to another room the same morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035247	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Gardens Post Acute	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The request for hospital records were provided on January 23, 2025 at 4:42 p.m. The admission physical assessment revealed resident #1 had 2 small hematomas on the frontal aspect and parietal aspect with overlying small lacerations that were closed with steri-strips. Further review of the hospital report revealed resident #1 informed hospital staff that he wanted to press charges and that security was notified to have a police report made. A review of the facility policy titled Charting and Documentation states all services provided to the resident, progress toward the care plan goals, or nay changes in the residents medical, physical, functional or psychosocial condition, shall be documented in the residents medical record. The medical record should facillitate communication between the interdisciplinary team regarding the resident's condition and response to care.