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	07/02/2026

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 - Some	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** Based on staff interviews, review of clinical record and policy review, the facility failed to protect the rights of 7 of 15 residents sampled (#6, #19, #22, #65, #66, #76, and #77) to be free from physical and verbal abuse between residents. The deficient practice could result in resident injury, psychological, or behavioral harm as well as continued resident to resident abuse.Findings include:Regarding Resident #66 and Resident #65:-Resident #66, the alleged victim, was re-admitted [DATE] with diagnoses that included major depressive disorder, mood disorder, cerebral infarction, aphasia, vascular dementia with behavioral disturbances, Schizoaffective disorder depressive type, and bipolar II disorder. The care plan revised on February 12, 2019 revealed that Resident #66 had a communication problem related to expressive aphasia secondary to cerebral vascular accident (CVA). The care plan also revealed that Resident #66 was able to make his needs known through few words and gestures and had a communication book but gets frustrated when asked to use it. Interventions included anticipating and meeting his needs, monitoring and documenting physical nonverbal indicators of discomfort or distress. The care plan initiated on February 31, 2023 revealed that Resident #66 had a mood problem related to psychological diagnoses. The care plan also revealed that Resident #66 exhibited demanding and aggressive behavior, verbal aggression towards staff and show signs in addition to physical aggression. Interventions included administering medications as ordered, monitor and record mood to determine if problems seem to be related to external causes.A quarterly minimum data set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 9, indicating that the resident had moderate cognitive impairment. A Change of Condition progress note dated June 2, 2024 revealed that at approximately 8:05 a.m. the patio monitor and Certified Nursing Assistants (CNA) alerted the nurse and other day nurse of an incident on the patio smoking area. The note further documented that Resident #66 was involved in a physical altercation with Resident #65 who hit Resident #66 in the mouth with Resident #65's closed fist. The Change of Condition noted documented that Resident #65 was upset that Resident #66 had his finger in his face and yelling at him. The note also revealed that Resident #65 stated to the nurse that he punched Resident #66.A Change in Condition Evaluation form dated June 2, 2024 revealed that Resident #66 was involved in a physical altercation with a peer in which Resident #66 was hit in the mouth by Resident #65 due to Resident #66 yelling at Resident #65. Further review of the evaluation form revealed no injuries to Resident #66. A Change of Condition progress note dated June 2, 2024 documented that nurse was monitoring resident due to physical altercation. The note documented that resident was hit in the right side of the jaw with closed fist and was now complaining of right sided jaw pain rating it a 6 out of 10. The progress note revealed that Resident #66 was given Tylenol and continued to be monitored. A Medication Administration (MAR) note for Resident #66, dated June 3, 2024 documented that that the administration of the Tylenol was effective and the pain was now a 0 out of 10. -Resident #65, the alleged perpetrator, was admitted [DATE] with diagnoses that included Schizophrenia, unspecified bipolar disorder, and unspecified intracranial injury without loss of consciousness. A care plan initiated on February 17, 2021 revealed that Resident #65 was that physical aggressor towards (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
	035247	A. Building B. Wing	07/02/2026

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 - Some	another resident. Interventions included assessing and anticipating resident's needs and giving Resident #65 as many choices as possible about care and activities. A care plan initiated July 19, 2021 revealed that Resident #65 had a behavior problem related to psychological diagnoses. The care plan revealed that Resident #65 exhibited behaviors including sexual inappropriateness at times with staff and peers, resistive to care when he doesn't get his way, and incites peers. Interventions included anticipating resident's needs and administering medications as ordered. A quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 indicating sever cognitive impairment. The MDS also documented that Resident #65 exhibited delusions, verbal behavior, and rejection of cares. A health status note dated June 2, 2024, revealed that Resident #65 was involved in a physical altercation with Resident #66 at 8:05 a.m. The health status note documented that the writer observed Resident #65 fighting with Resident #66 and were immediately separated. The note also revealed that Resident #65 admitted that he punched Resident #66 in the face. The note documented that Resident #65 stated that Resident #66 was yelling at him from the patio and he told Resident #66 to come closer. Resident #66 left the patio and approached Resident #65 pointing a finger at Resident #65. Resident #65 told the writer 'I did not like that so I punched him, he was up in my face I didn't know if he was going to hit me. I have the right to defend myself so I punched him.'A Change in Condition Evaluation form dated June 2, 2024 revealed that Resident #65 was involved in a physical altercation with a male peer in which Resident #65 punched Resident #66 in the face. The facility follow-up investigation report dated June 2, 2024 revealed that that the facility concluded that the allegations of abuse were inconclusive due to not getting a complete history from the individuals involved and witnesses could not corroborate the alleged event. An interview was conducted on July 2, 2026 at 8:17 a.m. with CNA (Staff #6) who stated that she remembered Resident #66 who liked to keep to himself and had a very hard time communicating with others. Staff #6 stated that he would at times get frustrated with staff or other residents if they could not understand him. An interview was conducted on July 2, 2026 at 9:23 a.m. with CNA (Staff #30) who stated that he remembered Resident #65 as being very aggressive especially when he got angry. Staff #30 stated that he was never physically aggressive with staff but they did have to watch him to make sure he did not get angry at other residents as he was known to get into altercations with residents. An interview was conducted on July 2, 2026 at 10:11 a.m., via telephone, with Hospitality Aid (Staff # 23) who stated that she was watching over the smokers and witnessed Resident #66 go over to Resident #65 yelling at him with his finger pointing at Resident #65. Staff #23 stated that she saw Resident #65 punch Resident #66 in the jaw and they started fighting. Staff #23 stated that they separated the residents and assessed Resident #66 but did not see any injuries. Regarding Resident #76, #77, and #19:-Resident #76, the alleged victim, was admitted on [DATE] with diagnoses that included bipolar disorder, neuromuscular dysfunction of bladder, major depressive disorder, post traumatic stress disorder (PTSD), and suicidal ideations.A care plan initiated on February 19, 2024 revealed that Resident #76 had a behavior problem related to psychological diagnoses monitoring for verbal aggression, panic attacks/terrors, the inability to sleep, and refusal of cares. Interventions included administering medications as ordered and intervening as necessary to protect the rights and safety of others. An annual MDS assessment dated [DATE] revealed a BIMS score of 15 indicating cognition is completely intact. The MDS further documented verbal behaviors and other behaviors not directed at others significantly interfering with the resident's participation in activities or social interactions. A summery for providers note dated July 19, 2024 documented a change of condition marked as other. Further review of the note provided no description of the incident but indicated that no injuries were noted, no pain, and no signs of distress. The note revealed that the primary care provider was contacted with recommendations of no new orders and to continue monitoring. A health status note dated July 20, 2024 documented that Resident #76 was on change of condition for status post physical altercation received. The health status note revealed that Resident #76 received no injuries and did not complain of pain.-Resident #77, the alleged perpetrator and victim, was admitted on [DATE] with diagnoses of (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	07/02/2026

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 - Some	dehydration and Schizoaffective disorder.An admission MDS assessment dated [DATE] revealed a BIMS score of 8 indicating moderate cognitive impairment. The admission MDS documented that Resident #77 exhibited delusions and other behavior symptoms not directed at others. A health status note dated July 19, 2024 documented that the writer was summoned to dining room by staff reporting that Resident #77 punched Resident #76 in the arm.A change of condition evaluation form dated July 19, 2024 documented that Resident #77 was involved in physical aggression on Resident #76 punching her in the arm.A health status note dated July 20, 2024 revealed that Resident #77 was on change of condition for physical aggression as the aggressor. The note revealed the resident was compliant with medications and no current behaviors.A care plan initiated on July 22, 2024 revealed that Resident #77 had behavior problems related to psychological diagnoses. The care plan documented that Resident #77 flicks his nipples in public and places himself on the floor crawling around. Interventions included anticipating the needs of the resident and intervening as necessary to protect the rights and safety of others.-Resident #19, the alleged perpetrator, was re-admitted on [DATE] with diagnoses of adjustment disorder with depressed mood, unspecified dementia with other behavioral disturbances. An admission MDS dated [DATE] revealed a BIMS score of 7, indicating severe cognitive impairment. The MDS assessment documented that the resident exhibited verbal behaviors which interferes with resident's participation in activities or social interactions. The assessment revealed that current behaviors are worse compared to previous assessments.A health status note dated July 5, 2024 revealed that Resident #19 was observed visiting with other residents in the common area when Resident #19 became upset with roommate and became verbally aggressive turning aggression towards staff.A behavior note dated July 11, 2024 revealed the writer witness Resident #19 be verbally aggressive with another resident and was redirected immediately. A Change of condition note dated July 19, 2024 revealed that Resident #19 was involved in a resident to resident altercation. The change of condition note documented that Resident #19 was the aggressor and pushed Resident #77. The note revealed that Resident #19 stated that she was defending her friend (Resident #76) because she is wheelchair bound and unable to defend herself.A change of condition evaluation form dated July 19, 2024 documented that Resident #19 was involved in physical aggression as the aggressor on Resident #77.A follow-up investigation report submitted July 25, 2024 revealed that on July 19, 2024 at approximately 5:10 p.m. Resident #76 was was sitting in the dining room when Resident #77 started 'flicking his own nipples outside of the dining room. The report revealed that Resident #76 went out and told Resident #77 to 'knock it off'. The report documented that Resident #77 followed Resident #76 back into the dining room calling her vulgar names and hit Resident #76 on the right arm. The report documented that as staff were separating the residents, Resident #19 came over and pushed Resident #77 away from Resident #76. The investigation report verified the incident based on Resident #76's reporting of the incident. An interview was conducted on July 2, 2026 at 8:17 a.m. with CNA (Staff #6) who stated that she remembered the incident and had to separate all the residents from each other. Staff #6 said she did not witness the initial altercation however she remembered the incident because after the incident took place they had to change staffing in the dining room to have one staff member have eyes on the residents while the other staff members prepare for the meal. Staff #6 stated that prior to the incident all staff would be busy getting residents and prepping food so there were no real eyes on the residents during this time which she indicated why it escalated because there were no eyes on the residents prior to the actual altercation.Regarding Resident #22 and Resident #6-Resident #22, the alleged victim, was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), major depressive disorder, and unspecified dementia without behavioral disturbances.A care plan revised on February 5, 2026 revealed that the Resident had behavior problems related to psychological diagnoses, exhibiting non-compliance with care plan, self-isolation, false accusations, and exit seeking. Interventions included anticipating Resident's needs and intervening as necessary to protect the rights and safety of others.A quarterly MDS assessment dated [DATE] revealed a BIMS score of (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	07/02/2026

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 - Some	12, indicating moderate cognitive impairment. The quarterly MDS revealed behaviors including rejection of cares and wandering. A struck out health status note dated June 27, 2026 at 2:11 p.m. from Licensed Practical Nurse (LPN/Staff #32) revealed that Resident #22 was found with Resident #6 standing over him. The note revealed that Resident #22 stated that Resident #9 walked up to him and began hitting him. The note also documented that the residents were found by staff hitting each other and Resident #22 was requesting Resident #6 to be moved from his room. The health status note revealed that the strike out reason listed was correction on June 27, 2026 at 2:13 p.m.A late entry health status note dated June 27, 2026 at 2:13 p.m. written by Staff #32 revealed that Resident #22 was present in his room while his roommate Resident #6 was standing in his room yelling, screaming and cursing at another CNA calling them names threatening to hit them. The health status note revealed that residents were separated and placed on 1:1 until Resident #6 was moved.A Change of Condition Evaluation form dated June 27, 2026 at 5:26 p.m. conducted by Staff #32, revealed that Resident #22 had received verbal aggression from Resident #6. The change of condition evaluation form revealed no new skin conditions to Resident #22. A health status note dated June 28, 2026 from staff #32 revealed the patient on change of condition for receiving physical aggression from Resident #6. The note revealed all vitals were in normal range and patient had no complaints of pain or discomfort. An electronic MAR note dated June 28, 2026 at 9:22 p.m. documented change of condition for receiving physical aggression. The MAR note revealed that the provider and responsible party were notified. The MAR note documented that the Receiver of physical aggression (Resident #22) is to be monitored every shift for 3 days. An interview was conducted on June 29, 2026 at 9:34 a.m. with Resident #22 who stated that on Saturday June 27, 2026 his roommate at the time Resident #6 came over to him and started hitting him in the bed. Resident #22 said they he fought back to protect himself until staff came in and separated us. Resident #22 stated that he bruised his left hand. They moved Resident #6 to another room and he stated he feels safe now. An observation of Resident #22 was conducted at 9:34 a.m. revealing a large bruise on Resident #22's left hand covered with a bandage reading '6/28' and initials. Notification was given to the Administrator (Staff #43) on June 29, 2026 at 10:54 a.m. advising the administrator the report of resident to resident altercation made by Resident #22. A Nursing note dated June 29, 2026 at 11:00 a.m. revealed skin check was completed on Resident #22 indicating a skin tear and discoloration on the left hand. -Resident #6, the alleged perpetrator, was admitted on [DATE] with diagnoses that included anoxic brain damage, communicating hydrocephalus, PTSD, major depressive disorder, unspecified dementia, and unspecified mood disorder. A care plan initiated on May 18, 2026 revealed that Resident #6 had a behavior problem related to psychological diagnosis monitoring for delusions, inability to sleep, labile moods, restlessness, and visual hallucinations exhibiting physical aggression with staff, verbally aggressive using vulgar language towards staff. The care plan documented that on May 15, 2026 Resident #6 was the initiator of verbal aggression and was placed on a 1:1 with no indication on time frame or indication of conclusion date.An admission MDS assessment dated [DATE] revealed a BIMS score of 1 indicating severe cognitive impairment. The MDS assessment documented that resident exhibited physical behaviors and other behaviors which significantly interferes with the resident's care and puts others at risk of physical injury. The MDS did not indicate the resident exhibiting verbal behaviors. The assessment documented that Resident #6 significantly intrudes on the privacy or activity of others. A behavior note dated June 22, 2026 at 1:00 p.m. revealed Resident #6 observed crying intermittently appearing visibly distressed. The behavior note documented that resident displayed rapid mood changes shifting from tearful to angry. The note revealed resident angrily paced around the room and unit repeatedly stating he wanted to leave, demonstrating exit-seeking behavior. Resident #6 remained agitated with the staff unable to redirect. A health status note dated June 22, 2026 at 4:14 p.m. revealed that 911 was called due to the inability for staff to calm and redirect Resident #6. The health status note revealed the police were not willing to take the resident despite the staffs wishes. An order dated June 22, 2026 revealed a change of condition for physical (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	07/02/2026

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 - Some	aggression with provider and responsible party notified. The order revealed monitoring of the resident every shift for physical aggression for three days with end date of June 26, 2026. An electronic MAR note dated June 24, 2026 revealed that during administration of Ativan resident was observed sitting in bed ripping his brief mumbling to self while punching the bed covers. An electronic MAR note dated June 25, 2026 revealed patient was awake, crying, removing brief and showing aggression towards staff. An electronic MAR note dated June 25, 2026 that resident attempted to hit CNA during one instance of agitation. A Physician Assistant (PA) Note dated June 26, 2026 revealed that staff reported to the PA ongoing episodes of physical aggression. The PA note documented that these episodes of physical aggression seem to be triggered in the afternoon. The PA note recommended a gradual dose reduction of quetiapine. to 25 mg by mouth twice daily. The PA note documented that staff are to monitor closely for behavioral changes, increased agitation, or worsening aggression during the step reduction. A draft note dated June 27, 2026 at 1:44 p.m. by Staff #32 revealed resident #6 was witnessed standing over his roommate Resident #22 hitting him. Residents were separated and Resident #6 was placed on 1:1. The draft note was observed in the medical record on June 29, 2026 at 10:00 a.m. A late entry health status note dated June 27, 2026 at 1:44 p.m. by staff #32 revealed Resident #6 standing in his own room yelling, screaming and cursing at CNA threatening to hit them while Resident #22 was present. This note was observed in the medical record on June 30, 2026 at 8:30 a.m. replacing the previous draft note. A physician's order dated June 27, 2026 by the PA revealed a change of condition for physical aggression. The order revealed to monitor resident for physical aggression for three days. This order was discontinued on June 29, 2026 at 11:12 a.m., by the medical director, after notification by surveyor of the allegations of abuse. The physician order revealed the reason for discontinuing order had incorrect indication. A Change of Condition Note dated June 29, 2026 at 1:47 p.m. by Staff #43 revealed resident involved in verbal aggression with staff while in the room with his roommate. A physician's order dated June 29, 2026 revealed change of condition for verbal aggression provider notified and family notified to be monitored for 3 days. A physician's order dated June 29, 2026 revealed change of condition order for 3 days to monitor for physical aggression monitoring resident every shift until July 2, 2026. A Follow-up Investigation Report signed July 2, 2026 revealed the facility concluded that the allegation was inconclusive even though the facility acknowledged witnessed contact was made by the residents as Resident #6 was attempting to climb into Resident #22's bed resulting in skin tear of Resident #22.An interview was conducted with Licensed Practical Nurse (LPN/Staff #32) on July 1, 2026 at 10:19 a.m. who stated that she did not witness the incident but was called to the incident, when she arrived there were three CNAs trying to separate both Resident #22 and Resident #6. Staff #32 stated she heard a CNA calling for nurse on the walkie when she got to the room the patients were separated. Staff # 32 stated that she struck out the initial progress reports regarding the physical altercation because she was told not to document what was reported to her by staff just what she observed. Staff #37 stated that the CNAs reported that the Residents were together fighting when they arrived on scene. Staff #37 stated that while she was talking to Resident #22 she noticed there was blood and the hand was assessed and bandaged. Staff #32 stated that resident to resident abuse is when a resident harms another resident. An interview was conducted with CNA (Staff # 50) on July 2, 2026 at 8:51 a.m. who stated that Resident #6 can get physically aggressive with staff especially if the Resident does not want to do the task. Staff #50 stated on June 27, 2026 she was on the patio when she heard the call from another CNA, Staff # 50 stated when she went in there Resident #6 was over Resident #22 while Resident #22 was on the ground in a sitting position next to the bed. Staff #50 stated that they moved Resident #6 to the foot of the bed and helped Resident #22 up from the ground that is when she noticed the blood on Resident #22's hand. Staff #6 stated that the nurses came in and helped bandage Resident #22. An interview was conducted with CNA (Staff # 30) on July 2, 2026 at 9:23 a.m. who stated that he arrived after the other CNAs had separated the residents and Resident #22 was back in his bed being tended to by the nurses. Staff #30 stated he took Resident #6 out of the room and (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	07/02/2026

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 - Some	stayed with Resident #6 as his 1:1 for the rest of the shift. Staff #30 stated that when resident to resident abuse occurs they first try and deescalate the situation, then provide care for any injuries, and then notify his superior of the incident right away within 2 hours. An interview was conducted with Assistant Director of Nursing (ADON/Staff #56) on July 2, 2026 at 12:12 p.m. who stated that she was the on call nurse on June 27, 2026 when Staff #32 had contacted her regarding an incident with Resident #22 and Resident #6. Staff #56 stated that Resident #6 was over the top of Resident #22 in his side of the bed they think because Resident #6 was trying to get into the bed. She stated that Residents were separated and the Director of Nursing decided to place Resident #6 on 1:1 care as he had shown increase aggression over the past two weeks. Staff #56 stated that physicians have been working on Resident #6's medications but he still shows signs of physical aggression in the afternoons. Staff #56 stated she called the Director of Nursing who had conversations with the Administrator afterwards. Staff #56 stated that family on both sides were called immediately but the police were not called.An interview was conducted with the Director of Nursing (DON/Staff #40) on July 2, 2026 at 1:12 p.m. stated that she was called on Saturday June 27, 2026 with notification that Resident #6 was trying to get into Resident #22's bed and that Resident #6 was getting physically and verbally aggressive with the staff while be separated off of Resident #22. Staff #40 stated that she instructed Staff #56 to place Resident #6 on 1:1 for physical aggression over the weekend. Staff #40 stated that physical abuse can be hitting grabbing slapping other residents and if there is an allegation or a concern that resident to resident happened then we would initiate the notification process followed by the investigation process. An interview was conducted with Administrator (Staff # 43) on July 2, 2026 at 1:37 p.m. stated that he was notified that Resident #6 was trying to get into Resident 22's bed and staff had to separate them. Staff #43 stated that he did not feel this was abuse because Resident #22 just wanted him out of the room. Staff #43 stated that they removed Resident #6 from the room and placed him in his own room with a 1:1 sitter as added precaution because of Resident #43's history with verbal & physical aggression. Staff #43 stated that he did not feel this was resident to resident abuse because there was not willful intent, even though Resident #6 was trying to get into Resident #22's bed.A Policy and Procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, Revised April 2021, revealed that residents have the right to be free from abuse including freedom from verbal and physical abuse. The policy revealed that the objective of the policy is to protect residents from abuse or misappropriation of property by anyone including other residents.

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	07/02/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to implement their abuse policy involving an allegation of abuse with 3 of 15 residents (#6, #22, and #80). The deficient practice could result in the appropriate State Agencies not being notified and allegations of abuse not being thoroughly investigated. -Regarding Resident #80 Resident #80 was admitted on [DATE] with diagnoses that included unspecified mood disorder, suicidal ideations, anxiety disorder, and depression. A Nurses Note dated May 15, 2026 7:08 a.m. revealed that the writer was alerted by Resident #80 that she had been in a physical altercation with a Certified Nursing Assistant (CNA #12). The nurses note goes on to reveal that prior to this incident Resident #80 was resistant to having CNAs helping her with a shower. The note documents that Resident #80 came out yelling stating she was in a fight with the CNA. The note also documented that there were some visible scratches to her arms but refused treatment to said areas. The note revealed that the Director of Nursing and Nurse Practitioner were notified of the allegation. A follow up nurses note by the Director of Nursing (DON/Staff #40) dated May 15, 2026 at 7:09 a.m. revealed that Resident #80 reported that the scratches were self inflicted as she hit her arms on the bed while grabbing the CNA. A Change of Condition evaluation dated May 15, 2026 at 7:15 p.m. revealed that Resident #80 came out of the room yelling that she didn't want CNA #12 in her room because they got into a fight. The change of condition note revealed that Resident #80 said she slapped and choked CNA #12. Review of physician orders revealed no change of condition orders or monitoring orders regarding the allegations made on May 15, 2026. A Medicare 5-day Minimum data set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 14, indicating the resident is cognitively intact. The MDS assessment revealed that Resident #80 suffers from delusions, physical and verbal behavior, and rejection of care and wandering. A care plan dated May 18, 2026 revealed that Resident #80 had behavior problems related to primary diagnosis of mood disorder and other psychological diagnoses. The care plan revealed that resident # 80 exhibited impatience with staff and exhibits false allegations, physical aggressive towards staff, and harms self when upset. Interventions include administer medications as ordered, and anticipate and meet the Resident's needs. A physicians order dated May 18, 2026 for cares in pairs. Three days after the first initial allegation of abuse. A Social Service Note dated May 19, 2026 revealed that Resident #80 had made statements indicative of suicidal ideation and requested to leave the facility. The social services note revealed that the Crisis team was called out to meet with Resident #80, who told the Crisis team that she has been beaten up by CNA #12 in a fight. The social services note documented per facility protocol regarding the allegation initially reported on 5/14/2026, the identified CNA was removed from assignment with the resident pending reviewing and the resident was put on cares in pairs.Review of CNA Staff #12 Time Report sheet revealed that Staff #12 worked the following shifts; May 14, 2026 2:04 p.m.-10:12 p.m. May 17, 2026 2:02 p.m.-10:06 p.m.May 18, 2026 1:58 p.m.-10:03 p.m. Further review of the the Time Report Sheets revealed that Staff #12 was pulled from the schedule on administrative paid leave on May 19 and May 20, 2026. An interview was conducted with CNA (Staff #6) on July 2, 2026 at 8:17 a.m. who stated that she had worked a lot with Resident #80 and had described Resident #80 as having a lot of anxiety. Staff #6 stated she had a good bond with Resident #80 and would light up and be happy when they interreacted but Staff #6 stated that it quickly changed a few days before the Crisis when she reported the altercation with another CNA. Staff #6 stated she did not who it was and Resident # 80 would not tell Staff #6 who it was or what they did. Staff #6 stated that she made her nurses aware but Resident #80 was known for making false accusations so not sure what was investigated. An interview was conducted with CNA (Staff #30) on July 2, 2026 at 9:23 a.m. who stated that he remembered Resident #80 because she was always sexually inappropriate with the men and it was hard to redirect her. Staff #30 stated that he was not there at the time but he heard (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	07/02/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the next day May 15, 2026 that Resident #80 had alleged abuse against Staff #12 and had bruises on her arms. An interview was conducted with Social Services Director (Staff # 91) on July 2, 2026 at 12:21 p.m. stated that Resident #80 was very combative with all the staff. Staff # 91 stated that she knew that Staff #12 had scratches on her from taking care of her. Staff #91 stated that she heard about the allegations made on May 15, 2026 but she stated that she was not given a name of who the CNA was until she made the second allegation on May 19, 2026. Staff #91 stated that is when they pulled her off the schedule. An interview was conducted with the Director of Nursing (DON/Staff #40) on July 2, 2026 at 1:12 p.m. stated that if there is an allegation staff to resident abuse notification would be made immediately to the abuse coordinator (Staff #43). Staff #40 stated that was notified by the agency nurse of the allegation that Resident #80 was involved in a fight with CNA #12. Staff #40 stated she conducted interview with Resident #80 and determined that Resident #80 was the only aggressor in the fight with Staff #12. Staff #40 did state that she reported to Staff #43 that same day of the allegations. Staff #40 stated that Staff #43 is responsible to report to the state agencies any allegations unless he is unavailable then Staff #40 state that it would be her responsibility. An interview was conducted with Administrator (Staff # 43) on July 2, 2026 at 1:37 p.m. stated that if there is an allegation of abuse then he reports to all reporting state agencies within two hours and then they conduct their investigation. Staff #43 stated that the allegation Resident #80 made of fighting CNA #12 was not considered reportable because during an interview of the resident Resident #80 stated she was the aggressor. Regarding Resident #22 and Resident #6:-Resident #22, the alleged victim, was admitted on [DATE] with diagnoses that included COPD, major depressive disorder, and unspecified dementia without behavioral disturbances.A care plan revised on February 5, 2026 revealed that the Resident has behavior problem related to psychological diagnoses, exhibiting non-compliance with care plan, self-isolation, false accusations, and exit seeking. Interventions include anticipating Resident's needs and intervening as necessary to protect the rights and safety of others.A quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. The quarterly MDS revealed behaviors including rejection of cares and wandering. A struck out health status note dated June 27, 2026 at 2:11 p.m. from Licensed Practical Nurse (LPN/Staff #32) revealed that Resident #22 was found with Resident #6 standing over him. The note revealed that Resident #22 stated that Resident #9 walked up to him and began hitting him. The note also documented that the residents were found by staff hitting each other and Resident #22 was requesting Resident #9 to be moved from his room. The health status note revealed that the strike out reason listed was correction on June 27, 2026 at 2:13 p.m.A late entry health status note dated June 27, 2026 at 2:13 p.m. written by Staff #32 revealed that Resident #22 was present in his room while his roommate Resident #6 was standing in his room yelling, screaming and cursing at another CNA calling them names threatening to hit them. The health status note revealed that residents were separated and placed on 1:1 until Resident #6 was moved.A Change of Condition Evaluation form dated June 27, 2026 at 5:26 p.m. conducted by Staff #32, revealed that Resident #22 had received verbal aggression from Resident #6. The change of condition evaluation form revealed no new skin conditions to Resident #22. A health status note dated June 28, 2026 from staff #32 revealed the patient on change of condition for receiving physical aggression from Resident #6. The note revealed all vitals were in normal range and patient had no complaints of pain or discomfort. An electronic MAR note dated June 28, 2026 at 9:22 p.m. documented change of condition for receiving physical aggression. The MAR note revealed that the provider and responsible party were notified. The MAR not documented that the Receiver of physical aggression (Resident #22) is to be monitored every shift for 3 days. An interview was conducted on June 29, 2026 at 9:34 a.m. with Resident #22 who stated that on Saturday June 27, 2026 his roommate at the time Resident #6 came over to him and started hitting him in the bed. Resident #22 said they he fought back to protect himself until staff came in and separated us. Resident #22 stated that he bruised his left hand. They moved Resident #6 to another room and he stated he feels safe now. An observation of Resident #22 was conducted at 9:34 a.m. (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	07/02/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealing a large bruise on Resident #22's left hand covered with a bandage reading 6/28 and initials. Notification was given to the Administrator (Staff #43) on June 29, 2026 at 10:54 a.m. advising the administrator the report of resident to resident altercation made by Resident #22. A Nursing note dated June 29, 2026 at 11:00 a.m. revealed skin check was completed on Resident #22 indicating a skin tear and discoloration on the left hand. Resident #6, the alleged perpetrator, was admitted on [DATE] with diagnoses that included anoxic brain damage, communicating hydrocephalus, PTSD, major depressive disorder, unspecified dementia, and unspecified mood disorder. A care plan initiated on May 18, 2026 revealed that Resident #6 had a behavior problem related to psychological diagnosis monitoring for delusions, inability to sleep, labile moods, restlessness, and visual hallucinations exhibiting physical aggression with staff, verbally aggressive using vulgar language towards staff. The care plan documented that on May 15, 2026 Resident #6 was the initiator of verbal aggression and was placed on a 1:1 with no indication on time frame or indication of conclusion date.An admission MDS assessment dated [DATE] revealed a BIMS score of 1 indicating severe cognitive impairment. The MDS assessment documented that resident exhibited physical behaviors and other behaviors which significantly interferes with the resident's care and puts others at risk of physical injury. The MDS did not indicate the resident exhibiting verbal behaviors. The assessment documented that Resident #6 significantly intrudes on the privacy or activity of others. A behavior note dated June 22, 2026 at 1:00 p.m. revealed Resident #6 observed crying intermittently appearing visibly distressed. The behavior note documented that resident displayed rapid mood changes shifting from tearful to angry. The note revealed resident angrily paced around the room and unit repeatedly stating he wanted to leave, demonstrating exit-seeking behavior. Resident #6 remained agitated with the staff unable to redirect. A health status note dated June 22, 2026 at 4:14 p.m. revealed that 911 was called due to the inability for staff to calm and redirect Resident #6. The health status note revealed the police were not willing to take the resident despite the staffs wishes. An order dated June 22, 2026 revealed a change of condition for physical aggression with provider and responsible party notified. The order revealed monitoring of the resident every shift for physical aggression for three days with end date of June 26, 2026. An electronic MAR note dated June 24, 2026 revealed that during administration of Ativan resident was observed sitting in bed ripping his brief mumbling to self while punching the bed covers. An electronic MAR note dated June 25, 2026 revealed patient was awake, crying, removing brief and showing aggression towards staff. Another electronic MAR note dated June 25, 2026 that resident attempted to his CNA during one instance of agitation. A Physician Assistant (PA) Note dated June 26, 2026 revealed that staff reported to the PA ongoing episodes of physical aggression. The PA note documented that these episodes of physical aggression seem to be triggered in the afternoon. The PA note recommended a gradual dose reduction of quetiapine. to 25 mg by mouth twice daily. The PA note documented that staff are to monitor closely for behavioral changes, increased agitation, or worsening aggression during the step reduction. A draft note dated June 27, 2026 at 1:44 p.m. by Staff #32 revealed resident #6 was witnessed standing over his roommate Resident #22 hitting him. Residents were separated and Resident #6 was placed on 1:1. The draft note was observed in the medical record on June 29, 2026 at 10:00 a.m. A late entry health status note dated June 27, 2026 at 1:44 p.m. by staff #32 revealed Resident #6 standing in his own room yelling, screaming and cursing at CNA threatening to hit them while Resident #22 was present. This not was observed in the medical record on June 30, 2026 at 8:30 a.m. replacing the previous draft note. A physician's order dated June 27, 2026 by the PA revealed a change of condition for physical aggression. The order revealed to monitor resident for physical aggression for three days. This order was discontinued on June 29, 2026 at 11:12 a.m., by the medical director, after notification by surveyor of the allegations of abuse. The physician order revealed the reason for discontinuing order had incorrect indication. A Change of Condition Note dated June 29, 2026 at 1:47 p.m. by Staff #43 revealed resident involved in verbal aggression with staff while in the room with his roommate. A physician's order dated June 29, 2026 revealed change of condition for verbal aggression provider (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	07/02/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified and family notified to be monitored for 3 days. A physician's order dated June 29, 2026 revealed change of condition order for 3 days to monitor for physical aggression monitoring resident every shift until July 2, 2026. A Follow-up Investigation Report signed July 2, 2026 revealed the facility reported the allegation of abuse only after the state agency brought it to their attention. The facility concluded that the allegation was inconclusive even though the facility acknowledged witnessed contact was made by the residents as Resident #6 was attempting to climb into Resident #22's bed resulting in skin tear of Resident #22.An interview was conducted with Licensed Practical Nurse (LPN/Staff #32) on July 1, 2026 at 10:19 a.m. who stated that she did not witness the incident but was called to the incident, when she arrived there were three CNAs trying to separate both Resident #22 and Resident #6. Staff #32 stated she heard a CNA calling for nurse on the walkie when she got to the room the patients were separated. Staff # 32 stated that she struck out the initial progress reports regarding the physical altercation because she was told not to document what was reported to her by staff just what she observed. Staff #37 stated that the CNAs reported that the Residents were together fighting when they arrived on scene. Staff #37 stated that while she was talking to Resident #22 she noticed there was blood and the hand was assessed and bandaged. Staff #32 stated that resident to resident abuse is when a resident harms another resident. An interview was conducted with CNA (Staff # 50) on July 2, 2026 at 8:51 a.m. who stated that Resident #6 can get physically aggressive with staff especially if the Resident does not want to do the task. Staff #50 stated on June 27, 2026 she was on the patio when she heard the call from another CNA, Staff # 50 stated when she went in there Resident #6 was over Resident #22 while Resident #22 was on the ground in a sitting position next to the bed. Staff #50 stated that they moved Resident #6 to the foot of the bed and helped Resident #22 up from the ground that is when she noticed the blood on Resident #22's hand. Staff #6 stated that the nurses came in and helped bandage Resident #22. An interview was conducted with CNA (Staff # 30) on July 2, 2026 at 9:23 a.m. who stated that he arrived after the other CNAs had separated the residents and Resident #22 was back in his bed being tended to by the nurses. Staff #30 stated he took Resident #6 out of the room and stayed with Resident #6 as his 1:1 for the rest of the shift. Staff #30 stated that when resident to resident abuse occurs they first try and deescalate the situation, then provide care for any injuries, and then notify his superior of the incident right away within 2 hours. An interview was conducted with Assistant Director of Nursing (ADON/Staff #56) on July 2, 2026 at 12:12 p.m. who stated that if there is an allegation of any kind of abuse especially resident to resident we would notify to the DON or the administrator immediately due to the time frame of reporting. Staff #56 state she was the on call nurse on June 27, 2026 when Staff #32 had contacted her regarding an incident with Resident #22 and Resident #6. Staff #56 stated that Resident #6 was over the top of Resident #22 in his side of the bed they think because Resident #6 was trying to get into the bed. She stated that Residents had to be separated and the Director of Nursing decided to place Resident #6 on 1:1 care as he had shown increase aggression over the past two weeks. Staff #56 stated that family on both sides were called immediately but the police were not called they did not think it was necessary as they had the situation under control. An interview was conducted with the Director of Nursing (DON/Staff #40) on July 2, 2026 at 1:12 p.m. stated that physical abuse can be hitting grabbing slapping other residents and if there is an allegation or a concern that resident to resident happened then we would initiate the notification process followed by the investigation process. Staff #40 stated was called on Saturday June 27, 2026 with notification that Resident #6 was trying to get into Resident #22's bed and that Resident #6 was getting physically and verbally aggressive with the staff while be separated off of Resident #22. Staff #40 stated that she instructed Staff #56 to place Resident #6 on 1:1 for physical aggression over the weekend. Staff #40 stated that she did contact the abuse coordinator Staff #43 and discussed the incident. An interview was conducted with Administrator (Staff # 43) on July 2, 2026 at 1:37 p.m. stated that if there is an allegation of abuse then he reports to all reporting state agencies within two hours and then they conduct their investigation. Staff #43 that he was notified that Resident #6 was (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	07/02/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trying to get into Resident 22's bed and staff had to separate them. Staff #43 stated that he did not feel this was abuse because Resident #22 just wanted him out of the room. Staff #43 stated that they removed Resident #6 from the room and placed him in his own room with a 1:1 sitter as added precaution because of Resident #43's history with verbal & physical aggression. Staff #43 stated that he did not feel this was resident to resident abuse because there was not willful intent and therefore was not reported. A policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, Revised April 2021, documented that if resident abuse is suspected the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy documented that 'immediately' is defined as within 2 hours of an allegation involving abuse resulting in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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	07/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility to ensure that an allegation of abuse for 3 out of 15 residents (#6, #22, and #80) was reported to all applicable state agencies within the required timeframe. The deficient practice could result in a delay in the proper investigation of abuse allegations. Findings include:Regarding Resident #80:Resident #80 was admitted on [DATE] with diagnoses that included unspecified mood disorder, suicidal ideations, anxiety disorder, and depression. A Nurses Note dated May 15, 2026 7:08 a.m. revealed that the writer was alerted by Resident #80 that she had been in a physical altercation with a Certified Nursing Assistant (CNA #12). The nurses note goes on to reveal that prior to this incident Resident #80 was resistant to having CNAs helping her with a shower. The note documents that Resident #80 came out yelling stating she was in a fight with the CNA. The note also documented that there were some visible scratches to her arms but refused treatment to said areas. The note revealed that the Director of Nursing and Nurse Practitioner were notified. A follow up nurses note by the Director of Nursing (DON/Staff #40) dated May 15, 2026 at 7:09 a.m. revealed that Resident #80 reported that the scratches were self inflicted as she hit her arms on the bed while grabbing the CNA. A Change of Condition evaluation dated May 15, 2026 at 7:15 p.m. revealed that Resident #80 came out of the room yelling that she didn't want CNA #12 in her room because they got into a fight. The change of condition note revealed that Resident #80 said she slapped and choked CNA #12. Review of physician orders revealed no change of condition orders or monitoring orders regarding the allegations made on May 15, 2026. A Medicare 5-day Minimum data set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 14, indicating the resident is cognitively intact. The MDS assessment revealed that Resident #80 suffers from delusions, physical and verbal behavior, and rejection of care and wandering. A care plan dated May 18, 2026 revealed that Resident #80 had behavior problems related to primary diagnosis of mood disorder and other psychological diagnoses. The care plan revealed that resident # 80 exhibited impatience with staff and exhibits false allegations, physical aggressive towards staff, and harms self when upset. Interventions include administer medications as ordered, and anticipate and meet the Resident's needs. A physicians order dated May 18, 2026 for cares in pairs. Three days after the first initial allegation of abuse. A Social Service Note dated May 19, 2026 revealed that Resident #80 had made statements indicative of suicidal ideation and requested to leave the facility. The social services note revealed that the Crisis team was called out to meet with Resident #80, who told the Crisis team that she has been beaten up by CNA #12 in a fight. The social services note documented per facility protocol regarding the allegation initially reported on 5/14/2026, the identified CNA was removed from assignment with the resident pending reviewing and the resident was put on cares in pairs.Review of CNA Staff #12 Time Report sheet revealed that Staff #12 worked the following shifts; May 14, 2026 2:04 p.m.-10:12 p.m. May 17, 2026 2:02 p.m.-10:06 p.m.May 18, 2026 1:58 p.m.-10:03 p.m. Further review of the the Time Report Sheets revealed that Staff #12 was pulled from the schedule on administrative paid leave on May 19 and May 20, 2026. An interview was conducted with CNA (Staff #6) on July 2, 2026 at 8:17 a.m. who stated that she had worked a lot with Resident #80 and had described Resident #80 as having a lot of anxiety. Staff #6 stated she had a good bond with Resident #80 and would light up and be happy when they interreacted but Staff #6 stated that it quickly changed a few days before the Crisis when she reported the altercation with another CNA. Staff #6 stated she did not who it was and Resident # 80 would not tell Staff #6 who it was or what they did. Staff #6 stated that she made her nurses aware but Resident #80 was known for making false accusations so not sure what was investigated. An interview was conducted with CNA (Staff #30) on July 2, 2026 at 9:23 a.m. who stated that he remembered Resident #80 because she was always sexually inappropriate with the (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	07/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	men and it was hard to redirect her. Staff #30 stated that he was not there at the time but he heard the next day May 15, 2026 that Resident #80 had alleged abuse against Staff #12 and had bruises on her arms. An interview was conducted with Social Services Director (Staff # 91) on July 2, 2026 at 12:21 p.m. stated that Resident #80 was very combative with all the staff. Staff # 91 stated that she knew that Staff #12 had scratches on her from taking care of her. Staff #91 stated that she heard about the allegations made on May 15, 2026 but she stated that she was not given a name of who the CNA was until she made the second allegation on May 19, 2026. Staff #91 stated that is when they pulled her off the schedule. An interview was conducted with the Director of Nursing (DON/Staff #40) on July 2, 2026 at 1:12 p.m. stated that if there is an allegation staff to resident abuse notification would be made immediately to the abuse coordinator (Staff #43). Staff #40 stated that was notified by the agency nurse of the allegation that Resident #80 was involved in a fight with CNA #12. Staff #40 stated she conducted interview with Resident #80 and determined that Resident #80 was the only aggressor in the fight with Staff #12. Staff #40 did state that she reported to Staff #43 that same day of the allegations. Staff #40 stated that Staff #43 is responsible to report to the state agencies any allegations unless he is unavailable then Staff #40 state that it would be her responsibility. An interview was conducted with Administrator (Staff # 43) on July 2, 2026 at 1:37 p.m. stated that if there is an allegation of abuse then he reports to all reporting state agencies within two hours and then they conduct their investigation. Staff #43 stated that the allegation Resident #80 made of fighting CNA #12 was not considered reportable because during an interview of the resident Resident #80 stated she was the aggressor. Regarding Resident #22 and Resident #6:-Resident #22, the alleged victim, was admitted on [DATE] with diagnoses that included COPD, major depressive disorder, and unspecified dementia without behavioral disturbances.A care plan revised on February 5, 2026 revealed that the Resident has behavior problem related to psychological diagnoses, exhibiting non-compliance with care plan, self-isolation, false accusations, and exit seeking. Interventions include anticipating Resident's needs and intervening as necessary to protect the rights and safety of others.A quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. The quarterly MDS revealed behaviors including rejection of cares and wandering. A struck out health status note dated June 27, 2026 at 2:11 p.m. from Licensed Practical Nurse (LPN/Staff #32) revealed that Resident #22 was found with Resident #6 standing over him. The note revealed that Resident #22 stated that Resident #9 walked up to him and began hitting him. The note also documented that the residents were found by staff hitting each other and Resident #22 was requesting Resident #9 to be moved from his room. The health status note revealed that the strike out reason listed was correction on June 27, 2026 at 2:13 p.m.A late entry health status note dated June 27, 2026 at 2:13 p.m. written by Staff #32 revealed that Resident #22 was present in his room while his roommate Resident #6 was standing in his room yelling, screaming and cursing at another CNA calling them names threatening to hit them. The health status note revealed that residents were separated and placed on 1:1 until Resident #6 was moved.A Change of Condition Evaluation form dated June 27, 2026 at 5:26 p.m. conducted by Staff #32, revealed that Resident #22 had received verbal aggression from Resident #6. The change of condition evaluation form revealed no new skin conditions to Resident #22. A health status note dated June 28, 2026 from staff #32 revealed the patient on change of condition for receiving physical aggression from Resident #6. The note revealed all vitals were in normal range and patient had no complaints of pain or discomfort. An electronic MAR note dated June 28, 2026 at 9:22 p.m. documented change of condition for receiving physical aggression. The MAR note revealed that the provider and responsible party were notified. The MAR not documented that the Receiver of physical aggression (Resident #22) is to be monitored every shift for 3 days. An interview was conducted on June 29, 2026 at 9:34 a.m. with Resident #22 who stated that on Saturday June 27, 2026 his roommate at the time Resident #6 came over to him and started hitting him in the bed. Resident #22 said they he fought back to protect himself until staff came in and separated us. Resident #22 stated that he bruised his left hand. They moved Resident #6 to another (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	07/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and he stated he feels safe now. An observation of Resident #22 was conducted at 9:34 a.m. revealing a large bruise on Resident #22's left hand covered with a bandage reading 6/28 and initials. Notification was given to the Administrator (Staff #43) on June 29, 2026 at 10:54 a.m. advising the administrator the report of resident to resident altercation made by Resident #22. A Nursing note dated June 29, 2026 at 11:00 a.m. revealed skin check was completed on Resident #22 indicating a skin tear and discoloration on the left hand. Resident #6, the alleged perpetrator, was admitted on [DATE] with diagnoses that included anoxic brain damage, communicating hydrocephalus, PTSD, major depressive disorder, unspecified dementia, and unspecified mood disorder. A care plan initiated on May 18, 2026 revealed that Resident #6 had a behavior problem related to psychological diagnosis monitoring for delusions, inability to sleep, labile moods, restlessness, and visual hallucinations exhibiting physical aggression with staff, verbally aggressive using vulgar language towards staff. The care plan documented that on May 15, 2026 Resident #6 was the initiator of verbal aggression and was placed on a 1:1 with no indication on time frame or indication of conclusion date.An admission MDS assessment dated [DATE] revealed a BIMS score of 1 indicating severe cognitive impairment. The MDS assessment documented that resident exhibited physical behaviors and other behaviors which significantly interferes with the resident's care and puts others at risk of physical injury. The MDS did not indicate the resident exhibiting verbal behaviors. The assessment documented that Resident #6 significantly intrudes on the privacy or activity of others. A behavior note dated June 22, 2026 at 1:00 p.m. revealed Resident #6 observed crying intermittently appearing visibly distressed. The behavior note documented that resident displayed rapid mood changes shifting from tearful to angry. The note revealed resident angrily paced around the room and unit repeatedly stating he wanted to leave, demonstrating exit-seeking behavior. Resident #6 remained agitated with the staff unable to redirect. A health status note dated June 22, 2026 at 4:14 p.m. revealed that 911 was called due to the inability for staff to calm and redirect Resident #6. The health status note revealed the police were not willing to take the resident despite the staffs wishes. An order dated June 22, 2026 revealed a change of condition for physical aggression with provider and responsible party notified. The order revealed monitoring of the resident every shift for physical aggression for three days with end date of June 26, 2026. An electronic MAR note dated June 24, 2026 revealed that during administration of Ativan resident was observed sitting in bed ripping his brief mumbling to self while punching the bed covers. An electronic MAR note dated June 25, 2026 revealed patient was awake, crying, removing brief and showing aggression towards staff. Another electronic MAR note dated June 25, 2026 that resident attempted to his CNA during one instance of agitation. A Physician Assistant (PA) Note dated June 26, 2026 revealed that staff reported to the PA ongoing episodes of physical aggression. The PA note documented that these episodes of physical aggression seem to be triggered in the afternoon. The PA note recommended a gradual dose reduction of quetiapine. to 25 mg by mouth twice daily. The PA note documented that staff are to monitor closely for behavioral changes, increased agitation, or worsening aggression during the step reduction. A draft note dated June 27, 2026 at 1:44 p.m. by Staff #32 revealed resident #6 was witnessed standing over his roommate Resident #22 hitting him. Residents were separated and Resident #6 was placed on 1:1. The draft note was observed in the medical record on June 29, 2026 at 10:00 a.m. A late entry health status note dated June 27, 2026 at 1:44 p.m. by staff #32 revealed Resident #6 standing in his own room yelling, screaming and cursing at CNA threatening to hit them while Resident #22 was present. This not was observed in the medical record on June 30, 2026 at 8:30 a.m. replacing the previous draft note. A physician's order dated June 27, 2026 by the PA revealed a change of condition for physical aggression. The order revealed to monitor resident for physical aggression for three days. This order was discontinued on June 29, 2026 at 11:12 a.m., by the medical director, after notification by surveyor of the allegations of abuse. The physician order revealed the reason for discontinuing order had incorrect indication. A Change of Condition Note dated June 29, 2026 at 1:47 p.m. by Staff #43 revealed resident involved in verbal aggression with staff while in the room with his roommate. A (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	07/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order dated June 29, 2026 revealed change of condition for verbal aggression provider notified and family notified to be monitored for 3 days. A physician's order dated June 29, 2026 revealed change of condition order for 3 days to monitor for physical aggression monitoring resident every shift until July 2, 2026. A Follow-up Investigation Report signed July 2, 2026 revealed the facility reported the allegation of abuse only after the state agency brought it to their attention. The facility concluded that the allegation was inconclusive even though the facility acknowledged witnessed contact was made by the residents as Resident #6 was attempting to climb into Resident #22's bed resulting in skin tear of Resident #22.An interview was conducted with Licensed Practical Nurse (LPN/Staff #32) on July 1, 2026 at 10:19 a.m. who stated that she did not witness the incident but was called to the incident, when she arrived there were three CNAs trying to separate both Resident #22 and Resident #6. Staff #32 stated she heard a CNA calling for nurse on the walkie when she got to the room the patients were separated. Staff # 32 stated that she struck out the initial progress reports regarding the physical altercation because she was told not to document what was reported to her by staff just what she observed. Staff #37 stated that the CNAs reported that the Residents were together fighting when they arrived on scene. Staff #37 stated that while she was talking to Resident #22 she noticed there was blood and the hand was assessed and bandaged. Staff #32 stated that resident to resident abuse is when a resident harms another resident. An interview was conducted with CNA (Staff # 50) on July 2, 2026 at 8:51 a.m. who stated that Resident #6 can get physically aggressive with staff especially if the Resident does not want to do the task. Staff #50 stated on June 27, 2026 she was on the patio when she heard the call from another CNA, Staff # 50 stated when she went in there Resident #6 was over Resident #22 while Resident #22 was on the ground in a sitting position next to the bed. Staff #50 stated that they moved Resident #6 to the foot of the bed and helped Resident #22 up from the ground that is when she noticed the blood on Resident #22's hand. Staff #6 stated that the nurses came in and helped bandage Resident #22. An interview was conducted with CNA (Staff # 30) on July 2, 2026 at 9:23 a.m. who stated that he arrived after the other CNAs had separated the residents and Resident #22 was back in his bed being tended to by the nurses. Staff #30 stated he took Resident #6 out of the room and stayed with Resident #6 as his 1:1 for the rest of the shift. Staff #30 stated that when resident to resident abuse occurs they first try and deescalate the situation, then provide care for any injuries, and then notify his superior of the incident right away within 2 hours. An interview was conducted with Assistant Director of Nursing (ADON/Staff #56) on July 2, 2026 at 12:12 p.m. who stated that if there is an allegation of any kind of abuse especially resident to resident we would notify to the DON or the administrator immediately due to the time frame of reporting. Staff #56 state she was the on call nurse on June 27, 2026 when Staff #32 had contacted her regarding an incident with Resident #22 and Resident #6. Staff #56 stated that Resident #6 was over the top of Resident #22 in his side of the bed they think because Resident #6 was trying to get into the bed. She stated that Residents had to be separated and the Director of Nursing decided to place Resident #6 on 1:1 care as he had shown increase aggression over the past two weeks. Staff #56 stated that family on both sides were called immediately but the police were not called they did not think it was necessary as they had the situation under control. An interview was conducted with the Director of Nursing (DON/Staff #40) on July 2, 2026 at 1:12 p.m. stated that physical abuse can be hitting grabbing slapping other residents and if there is an allegation or a concern that resident to resident happened then we would initiate the notification process followed by the investigation process. Staff #40 stated was called on Saturday June 27, 2026 with notification that Resident #6 was trying to get into Resident #22's bed and that Resident #6 was getting physically and verbally aggressive with the staff while be separated off of Resident #22. Staff #40 stated that she instructed Staff #56 to place Resident #6 on 1:1 for physical aggression over the weekend. Staff #40 stated that she did contact the abuse coordinator Staff #43 and discussed the incident. An interview was conducted with Administrator (Staff # 43) on July 2, 2026 at 1:37 p.m. stated that if there is an allegation of abuse then he reports to all reporting state agencies within two (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	07/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours and then they conduct their investigation. Staff #43 that he was notified that Resident #6 was trying to get into Resident 22's bed and staff had to separate them. Staff #43 stated that he did not feel this was abuse because Resident #22 just wanted him out of the room. Staff #43 stated that they removed Resident #6 from the room and placed him in his own room with a 1:1 sitter as added precaution because of Resident #43's history with verbal & physical aggression. Staff #43 stated that he did not feel this was resident to resident abuse because there was not willful intent and therefore was not reported. A policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, Revised April 2021, documented that if resident abuse is suspected the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy documented that the administrator or the individual making the allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility, local/state ombudsman, resident's representative, Adult Protective Services, Law enforcement officials, and the resident's attending physician. The policy revealed that 'immediately' is defined as within 2 hours of an allegation involving abuse resulting in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.