

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Maryland Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 31 West Maryland Avenue Phoenix, AZ 85013	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, facility documentation, and policy review, the facility failed to ensure one resident (#27) received pain medication per physician ordered parameters. The deficient practice placed the resident at risk for receiving medication outside physician-prescribed parameters, which could result in unnecessary medication exposure and adverse drug reactions. The universe was 18 and the sample size was 6. Findings include: Resident #27 was admitted on [DATE], with diagnoses including rheumatoid arthritis, extrapyramidal and movement disorder, muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. A physician order dated June 18, 2025, revealed an order for Sulindac Tablet 200 mg, one tablet by mouth two times a day at 0800 and 2000 for pain related to rheumatoid arthritis. The order specified administration for pain rated 1-10. Additional physician orders included routine pain monitoring utilizing a 0-10 pain scale every shift beginning November 1, 2023, and post-pain level monitoring three times daily beginning February 28, 2025. A black box warning was associated with the order, stating cardiovascular and thrombotic risks were associated with this medication. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment further revealed the resident experienced pain, received a pain medication regimen within the previous five days, received non-pharmacological pain interventions, reported occasional pain that rarely affected sleep, did not interfere with therapy, occasionally interfered with day-to-day activities, and had a documented pain intensity score of 2. Clinical record review of the June 2026 Medication Administration Record (MAR) revealed Sulindac was administered at 0800 and 2000 outside of parameters for 27 out of the 30 days in the month of June 2026. Review of corresponding pain monitoring documentation revealed the resident's pain score was documented as 0 (no pain) for the majority of June 2026, with documented pain scores of 5, 8, and 3 only on June 25, June 29, and June 30, respectively. Further review revealed Sulindac was administered only five times within the physician-ordered pain parameter of 1-10 during the previous 60 days between May 1, 2026 and June 30, 2026, while the medication continued to be administered despite documented pain scores of 0 on numerous occasions. An interview was conducted with Resident #27 on July 1, 2026, at 9:07 AM. The resident stated she experienced pain in both hands, particularly her left hand, reported difficulty opening bags and pulling down her pants due to hand pain, and stated the bilateral hand splints had been helpful. An interview was conducted on July 1, 2026, at 2:29 PM with Certified Nursing Assistant (CNA/Staff #4) Staff #4 stated she generally became aware of the residents' pain when the resident requested pain medications or tylenol for her hand pain. She further stated that she reports these requests to the nurse and the nurse should follow up with the resident's needs. An interview was conducted on July 1, 2026, at 2:35 PM with Registered Nurse (RN/Staff #19) Staff #19 stated nurses rely on physician orders for resident treatments and medications. During review of the resident's electronic health record (EHR) and medication orders, he confirmed the Sulindac order specified administration for pain rated 1-10. He further stated that based on the way the order was written, he would want to call the physician and ask whether the medication should be administered when the resident's pain score was documented as 0. He stated he administered the Sulindac this morning and that the medication administration record shows Sulindac was administered outside of parameters in the month of June. He stated the risks of administration outside the physician's ordered parameters could expose the resident to adverse effects, including cardiovascular and thrombotic risks associated with (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Maryland Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 31 West Maryland Avenue Phoenix, AZ 85013	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	non-steroidal anti-inflammatory medications. An interview was conducted on July 1, 2026, at 3:09 PM with the Director of Nursing (DON), Staff #13. The DON confirmed the resident had an active physician order for Sulindac to be administered for pain rated 1-10 and acknowledged the medication had been administered despite documented pain scores of 0. The DON stated a pain score of 0 indicates the resident has no pain and confirmed the medication should not have been administered outside the physician's ordered parameters. The DON further stated administering medication contrary to the physician's order could result in adverse drug reactions and constituted a failure to follow physician orders. A progress note by a Family Nurse Practitioner (FNP) dated July 1, 2026 at 6:55 PM, revealed, A pain scale was entered incorrectly for scheduled medication for pain (Sulindac). The pain scale was not needed and will not be needed going forward. The previous order for Sulindac was modified to Sulindac Tablet 200 MG Give 1 tablet by mouth two times a day for Pain. On July 2, 2026, the facility provided MedlinePlus drug information on Sulindac. The information revealed People who take nonsteroidal anti-inflammatory medications (NSAIDs) (other than aspirin) such as sulindac may have a higher risk of having a heart attack or a stroke than people who do not take these medications. These events may happen without warning and may cause death. This risk may be higher for people who take NSAIDs for a long time. Do not take an NSAID such as sulindac if you have recently had a heart attack, unless directed to do so by your doctor. Tell your doctor if you or anyone in your family has or has ever had heart disease, a heart attack, or a stroke, if you smoke, and if you have or have ever had high cholesterol, high blood pressure, or diabetes. Get emergency medical help right away if you experience any of the following symptoms: chest pain, shortness of breath, weakness in one part or side of the body, or slurred speech. If you will be undergoing a coronary artery bypass graft (CABG; a type of heart surgery), you should not take sulindac right before or right after the surgery. NSAIDs such as sulindac may cause ulcers, bleeding, or holes in the stomach or intestine. These problems may develop at any time during treatment, may happen without warning symptoms, and may cause death. The risk may be higher for people who take NSAIDs for a long time, are older in age, have poor health, or drink large amounts of alcohol while you are taking sulindac. On July 2, 2026, the facility provided documentation and in-service records of staff education on medication administration and parameters. The subjects included Proper Medication Administration, dated July 1, 2026 for 15 minutes and Reviewing the 'Order Line Listing' daily and clarifying orders if needed with the provider(s), dated July 1, 2026 for 30 minutes. Review of the facility policy titled Pain Assessment and Management, revised October 2022, stated the purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Recognizing pain. Review the medication administration record to determine how often the individual requests and receives PRN pain medication, and to what extent the administered medications relieve the resident's pain. Implementing Pain Management Strategies. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and facility policy, the facility failed to ensure multiple food items were stored, labeled, and dated in accordance with professional standards, and failed to wash, rinse, and sanitize dishware in accordance with the manufacturer's instructions. The deficient practice places residents at risk for complications from foodborne illness. The universe was 79. Findings include: An initial observation of the kitchen was conducted on June 29, 2026, at 8:11 A.M. with the Dietary Manager (Staff #57). Observations were made of the large walk-in refrigerator, freezer, and dry storage area revealing the following deficiencies: -2 pound bag of mixed vegetables open and exposed to air with no open or use-by date-One 5 pound bag of corn open and exposed to air with no open or use-by date-One 6 pound bag of corn open and exposed to air with no open or use-by date-Approximately 4 pounds of [NAME] Dean sausage patties open and exposed to air with no open or use-by date-One package of cheese slices with no open or use-by date-One half full 30 ounce cup of McDonald's tea observed in the freezer. The dietary manager confirmed that it belonged to an employee.-Approximately 2 pounds of smoked ham with no open or use-by date-Approximately 1/2 pounds of sliced turkey with no open or use-by date-One open package of turkey slices with no open or use-by date-One expired Branched-Chain Amino Acids (BCAA) recovery protein supplement. The dietary manager confirmed that it belonged to an employee.-Half-and-half creamers stored with cucumbers and zucchini in the same box-Approximately 2 pounds of romaine lettuce open and exposed to air with an expiration date of June 25, 2026-One orange stored on the floor-One molded zucchini with fuzzy white spots-One food container observed on the floor-Approximately 15 green bell peppers with black discoloration and signs of spoilage-18 salsa and dessert containers with no lids open and exposed to air- One box of tomatoes with no use-by date- One box of onions with no use-by date-one unsealed package of bacon opened and exposed to air -Five gallons of milk with an expiration date of June 25, 2026-Sediment and dirt observed around refrigerator fan units-One package of hamburger buns with no open or use-by date-Debris, dust, and dirt observed on the ceiling of the kitchen-Sugar spilled on the floor in the dry storage area -One opened 50 pound bag of sugar exposed to air- One opened 50 pound bag of brown sugar exposed to air- One opened bag of oats exposed to air with no use-by date-Three opened bags of cornbread mix open and exposed to air with no use-by date-Two containers of rice with rice spillage, dust and debris on the handles, and rice debris on the floor-One 3 pound bag of macaroni open with no use-by date-Air filters and light fixtures with visible gray dust and debris on them-Ice scoop holder containing liquid and sediment at the bottom-Brown sediment and buildup observed around the interior and exterior of the ice machine- Two dead cockroaches were observed, one in the dishwasher drain and the other underneath the stove.An interview was conducted on June 29, 2026 at 8:11 A.M. with the Dietary Director (Staff #57). He stated that all food items are required to be labeled with both the date opened and the use-by date upon opening. He stated that food maintained beyond its use-by date or left uncovered could result in contamination. Staff #57 stated he provides in-service training to dietary staff regarding proper food labeling, dating, storage, first-in, first-out (FIFO) practices, and sanitation, and stated that kitchen staff possess food handler's cards and are expected to follow these procedures. A second observation of the kitchen was conducted on June 30, 2026, at 8:53 A.M., which revealed the following deficiencies:-Approximately 30 pieces of garlic toast were stored open to air in a box with the bag untied.-An employee's Coca-Cola bottle was observed stored in the kitchen- A package of (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	turkey slices was observed open and exposed to the air.-Spillage, debris, and sediment were observed along the edges of the refrigerator.-Dust and sediment were observed above the stove, creating a risk of contamination to food and a potential fire hazard.-Grime and debris were observed on the floor beneath kitchen tables-One container of cereal had no expiration date.-Dirt and debris were observed in the corners of the kitchen counters, and dirt, hair, and food debris were observed in a floor drain.An observation was conducted on June 30, 2026, at 8:53 A.M of the low-temperature chemical dishwasher which revealed a final rinse temperature of 135 degrees Fahrenheit. A sanitizer test strip (litmus test) indicated no detectable sanitizing chemical was being dispensed while the dishwasher was operating. At the time of the observation, approximately 32 bowls, 16 plates, 12 cups, and 7 trays had been washed through the dishwasher without detectable sanitizer.A poster containing the manufacturer's operating instructions for the low-temperature dishwasher, produced by [NAME] Chemical, was observed posted on the wall above the dishwasher. The posted instructions directed staff to check chemical levels to make sure products are available. Refill or replace as necessary and to check low temp sanitizer level minimum once per day. Range = 50-100 PPM. After the observation, an interview was conducted with staff #61. He stated he did not verify if sanitizer is being dispensed today, but sometimes he does. He further stated that the risk of not verifying sanitizer concentration was residents becoming sick.An observation was conducted on June 30, 2026 at 9:15 A.M. Staff #57 tested three quaternary ammonium (QAC) sanitizer buckets used for food preparation surfaces. All three sanitizer buckets measured 50 parts per million (ppm). An interview was conducted on July 2, 2026, at 9:39 A.M. with the Dietary Director (Staff #57). Staff #57 stated he has served as the Dietary Director, Housekeeping Director, and Laundry Director for the past three years. He stated he has over 20 years of dietary experience and is responsible for training staff on food storage, labeling, date marking, and proper washing procedures. He stated he conducts in-service training and acknowledged that staff had been under the impression that placing only one date on opened food items was sufficient. He stated he is responsible for providing the training and following up with staff to ensure food items are properly labeled with both open and use-by dates. He stated the Administrator also conducts periodic kitchen visits and has previously identified food items that were opened without use-by dates. He stated it is his responsibility to verify food products are properly labeled and dated and that he performs a walkthrough of the kitchen each morning. He further stated he expects cooks to assist in identifying improperly labeled food items and to ensure dietary aides and activity staff properly date any food items they access. He stated all dietary staff possess food handler cards. He stated that he assists with receiving food deliveries, oversees FIFO rotation, and guides dietary aides and cooks during storage. He stated he did not look but should have at the numerous unlabeled and improperly stored food items identified during the survey. He stated kitchen vents are typically cleaned every Wednesday to reduce the potential for fire and cross-contamination from accumulated debris. He stated staff are now responsible for cleaning the vents weekly. He stated the risks of not properly storing and rotating food is foodborne illness.An interview was conducted on July 2, 2026, at 12:00 P.M. with the Maintenance Director (Staff #106). Staff#106 stated he has worked at the facility for almost four years. He further stated the facility replaces HVAC filters approximately every three months and changes them sooner if they become excessively dirty. He stated maintenance changes the water filters for the ice machine and performs routine oil cleaning on the ice machine. He stated the hood filters are cleaned by running them through the dishwasher monthly, while the hood exhaust system receives professional servicing every six months. He further stated kitchen staff are responsible for cleaning the hood and vents between scheduled maintenance, including wiping down the exterior surfaces. He stated he has not personally cleaned the kitchen hood, but maintenance (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recently replaced the silicone around the hood. Staff #106 stated the dishwasher machine is leased and he was unsure whether the vendor performs routine inspections. He further stated maintenance does not routinely inspect the refrigerators beyond verifying that the units are maintaining appropriate temperatures. An interview was conducted on July 02, 2026 at 2:11 P.M. with the Administrator (Staff #43). He stated it is the responsibility of the kitchen staff to inspect the food and that per the facility's policy, food must be dated. A review of the facility policy titled Food Receiving and Storage with a revision date of November 2022 states foods shall be received and stored in a manner that complies with safe food handling practices. Dry foods that are stored in bins are removed from original packaging, labeled and dated. Such foods are rotated using a first in - first out system. Food in designated dry storage areas are kept at least six (6) inches off the floor (unless packaged for case lot handling, for example, dollies, pallets, racks and skids) and clear of sprinkler heads, sewage/waste disposal pipes and vents. All foods stored in the refrigerator or freezer are covered, labeled and dated. Refrigerated foods are labeled, dated and monitored so they are used following appropriate state/food guidelines.		

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of the Facility Guidelines Institute 2018 edition for Residential healthcare and Support Facilities, the facility failed to provide the required square footage per person for 4 out of 17 sampled rooms. The deficient practice does not allow safe and free movement in their living space. Findings include: An observation of 4 resident rooms (#312, # 315, #317 and #301) was conducted with the Maintenance Director (staff #106) on July 2, 2026 at 11:47 a.m. The following were the measurements obtained by the Maintenance Director using his own metal tape measure: room [ROOM NUMBER] was occupied by two residents, and had a measurement that totaled 137.04 square feet. This would give 68.52 sq. ft. per resident. Rooms 315 was occupied by four residents each. The total square footage on the usable space was of 260.6 square feet. This would provide 65.15 square feet of living space per resident. room [ROOM NUMBER] was occupied by four residents. The total square footage on the usable space was of 260.6 square feet. This would provide 65.15 square feet of living space per resident. room [ROOM NUMBER] had 5 residents. The total square footage of the room was 158.63 square feet. This resulted in 79.315 sq. ft. per resident. An interview was conducted on July 2, 2026 at approximately 2:00 p.m. with Administrator (Staff #43) stated that several inspections had been done in the past and this was never mentioned; and, he asked to have each of the sampled room size issues to be grandfathered in. The Facility Guidelines Institute 2018 edition for Residential healthcare and Support Facilities, under 3.1-2.2.2.2 Space Requirements included that resident rooms shall be sized, arranged and furnished to maximize safe resident mobility, mobilization, weight-bearing activity, ambulation potential and to minimize risk to caregivers. This requirements shall apply to all resident rooms, regardless of resident weight or condition. Every bed location shall have sufficient space to permit placement of a stretcher along one side for lateral transfer of the resident from the bed to the stretcher by at least 2 staff members without substantial rearrangement of furniture. The area and dimensions provided for each resident shall be based on the inclusion of the following: Space to accommodate a maximum of 2 beds that allows staff members access to both sides and the foot of each bed; A wardrobe or closet accessible from a wheelchair or other resident operated mobility device; Furniture accessible from a wheelchair of other resident-operated device - bed, lounge chair, dresser and night stand Clearance for staff members to use lifting equipment to access the bed, chairs and toilet.		

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. Based on dining observations and interviews, the facility failed to have sufficient space to accommodate all dining activities. The deficient practice resulted in residents not having a dining area that accommodates residents' physical needs. The census was 79. Findings include: An observation was conducted on June 29, 2026 between 11:52 A.M. and 12:25 P.M. The facility had one dining room for residents residing in the long-term care unit. The dining area had one small area to accommodate six residents who needed assistance with their eating. Within this small space, there was one large dining table to accommodate the six residents sitting across from each other and one on each end. The table sat approximately 2 feet from the kitchen counter where staff picked up resident meals. Within this space, there were three large metal meal carts, two blue coolers on stands, and one coffee stand. Observed staff picking up trays from the kitchen counter, bumping against the residents' wheelchairs to get to the other dining section area. These residents were also observed to be moved to accommodate other residents coming to their dining tables. In the other area of the dining room, observations of multiple residents were observed with limited room to accommodate leg rests, bariatric wheelchairs, and electric wheelchairs. Many of these residents were unable to sit up close to their tables due to their leg rest budding against the other residents leg rest. There was one resident observed directly beneath the speakers and television which was at a very loud level. Resident #49 was observed leaning to his left side. CNA was observed repositioning this resident. At 11:56 A.M., 20 residents were present in the dining room with approximately five to six staff members assisting. Resident #50 was observed in a large electric wheelchair where he had to sit with his back against the wall of the dining room, having to sit sideways to eat his meal. Due to the limited space, the resident spilled his juice on his pants and shirt. He was observed having difficulty trying to reach over to his plate to feed himself. Additional residents continued entering the dining room. Residents were seated three to four per square table. At 11:59 A.M., 33 residents were observed seated in the dining room. The dining room was observed to have limited space for residents being brought into the dining room for lunch. At 12:12 P.M., 37 residents were observed eating lunch in the main dining room. At 12:25 p.m., half of the residents had received their meal while others were still waiting to be served. An interview was conducted on July 1, 2026 at 10:00 A.M. with resident #50. He stated that he dislikes eating in the dining room due to the noise and limited space. He further stated there were too many people in the dining room, that it's so loud where you can't hear your neighbors speak, and it's too crowded for his wheelchair. He stated sometimes he has to be moved out of the way by staff members to make room for more people. He also stated that residents usually eat outside in the open courtyard where pigeons gather and fly around while eating their meals. An interview was conducted on July 1, 2026 at 8:24 A.M. with Certified Nursing Assistant (CNA/Staff #7). She stated there is not enough room for residents in the dining room and it gets really crowded so sometimes they use the patio as an overflow to accommodate the residents. An observation was conducted on July 2, 2026, at 7:58 A.M. Residents were observed eating breakfast on the outdoor patio due to limited indoor dining space. A resident was observed seated at a cement patio table while receiving breakfast assistance from the Social Services Director (Staff #91). Bird droppings were observed around the perimeter of the table and smeared on the tabletop directly in front of the resident while the resident was eating. Staff stated she had wiped the table with a disinfectant wipe but had not noticed the bird droppings on the sides of the table. An interview was conducted on July 2, 2026, at 8:00 A.M. with the Assistant Director of Nursing (ADON/Staff #56). She stated the patio is cleaned every Friday and (continued on next page)		

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	acknowledged pigeons have been an ongoing problem because residents feed them. She further stated bird droppings frequently fall on staff clothing. An interview was conducted on July 2, 2026, at 9:39 A.M. with the Dietary, Housekeeping, and Laundry Director (Staff #57). Staff #57 stated he has been discussing two meal services because it is pretty tight in the dining hall. He further stated the facility had recently admitted more residents, and that the activities staff had also discussed implementing two meal services. He stated he did not know the maximum dining room capacity or applicable safety code occupancy. A request was placed on July 2, 2026 at 10:21 A.M. for the facility's policy on accommodations for dining. An interview was conducted with the resident #64 on July 2, 2026 at approximately 10:30 A.M., She stated residents are routinely required to eat outside and reported birds frequently fly overhead, dropping feathers and feces on residents and their meal trays. The resident stated, I hate eating outside. We are only eating inside because you guys are here now. She further stated that she hurries while eating in the dining hall to get out of there because it's too much for me. Another resident, resident #3, confirmed the concern, stating, Half the time you don't know if it's raining or birds are pooping on you. They try to steal your food when we are eating. Both residents stated they usually eat meals on the outdoor patio. An interview was conducted on July 2, 2026 at 11:26 A.M. with the administrator (Staff #43). He stated that the facility does not have an official policy for accommodations for dining. A request was placed on July 2, 2026 at 2:21 P.M for the state code for number of residents allowed in the dining hall, and the standard occupancy for dining hall as issued by a government or code organization. The administrator stated that the facility has the facility's minimum egress requirements under the 1997 Uniform Building Code, which revealed only the occupant load factor of 15 square feet per person, which converts to 1.39 square meters per person. He further stated that he did not see a maximum occupancy sign in the dining hall. Review of the facility policy titled Resident Rights, revised February 2021, stated that Federal and state laws guarantee basic rights to all residents of this facility. These rights include the resident's right to: B. be treated with respect, kindness, and dignity		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, staff interviews, clinical record review, facility documentation, and policies and procedures, the facility failed to ensure medical records remained confidential for one resident (#7). The deficient practice could result in unauthorized visibility to residents' personal and medical records that compromise residents' right to privacy and confidentiality. The universe was 17, and the sample was 1. Findings include: An observation was conducted on July 01, 2026, at 11:54 AM of Licensed Practical Nurse (LPN/staff #28). Staff #28 completed medication administration for resident #7 and returned to the medication cart, located in the patio walkway outside the resident's room. At 11:55 AM, staff #28 locked the medication cart and walked away to return medication to the medication room, leaving the laptop powered on and unlocked. The unattended laptop screen displayed resident #7's name, date of birth, and medications. While the laptop remained unattended and unlocked, surveyors and facility staff walked through the patio walkway and around the location of the medication cart. At 11:56 AM, Staff #28 returned to the medication cart while speaking on a cellphone and resumed use of the laptop. An interview was conducted with Staff #28 on July 01, 2026 at 11:57 AM. Staff #28 was asked to identify the risks associated with leaving an unlocked laptop displaying resident information unattended. Staff #28 stated the risk was to HIPAA (Health Insurance Portability and Accountability Act) and the importance of maintaining HIPAA is to protect residents. Staff #28 stated resident #7's information had been visibly displayed while the laptop was unattended. An interview was conducted on July 02, 2026, with the Director of Nursing (DON/staff #40). Staff #40 stated the facility's expectations for protecting residents' confidentiality are to abide by HIPAA. She further stated staff are expected to protect resident confidentiality by locking or fully closing laptops and turning over paperwork containing resident information whenever leaving a workstation unattended. Staff #40 stated leaving resident information visible on an unlocked laptop does not meet facility expectations and further stated the risk of not maintaining HIPAA compliance is that the facility is giving people access to protected information, which is a violation of state and federal law. Review of the facility policy titled Resident Rights, with a revision date of February 2021, states employees shall treat all residents with kindness, respect, and dignity. 4. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA compliance officer. Review of the facility policy titled HIPAA Policy & Procedure, with a revision date of February 2026, revealed a policy statement to protect patient privacy and confidentiality and safeguard Protected Health Information (PHI) in all forms (verbal, written, electronic) and a procedure to: 8. log out of EHR systems after use.		

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NAME OF PROVIDER OR SUPPLIER Maryland Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 31 West Maryland Avenue Phoenix, AZ 85013	
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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 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

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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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Maryland Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 31 West Maryland Avenue Phoenix, AZ 85013	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#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 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.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policy review, the facility failed to ensure the care plan was revised for one resident (#27) regarding bilateral hand splints. The deficient practice could result in inaccuracies regarding resident care and omission of required interventions related to range of motion (ROM) and splint use. The sample size was 1 and the universe was 79. Findings include: Resident #27 was admitted to the facility on [DATE], with diagnoses including rheumatoid arthritis, unspecified movement disorder, muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. A review of the resident's care plan, dated January 17, 2023, revealed a focus for pain related to rheumatoid arthritis and limited mobility. Interventions included pain meds as ordered. Further review of the care plan revealed a focus for limited mobility. Interventions included to encourage the resident to participate to the fullest extent possible with each interaction. A physician order dated March 29, 2025 revealed Patient to wear bilateral hand splints daily as tolerated in order to maintain ROM. A review of the most recent quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Further review revealed the resident had rheumatoid arthritis, pain, occasional interference with day-to-day activities, and no current therapy services. A review of the resident's care plan, dated June 16, 2026, revealed no focus for the physician's order for bilateral hand splints or interventions addressing daily splint use, monitoring, or maintenance of range of motion. During initial screening, an observation was conducted on June 29, 2026 at 9:10 a.m. of the resident's hands. The fingers were observed bent and drifting sideways toward the pinky finger. During an interview with resident #27, she stated that she had rheumatoid arthritis. An interview was conducted on July 1, 2026, at 9:07 a.m. with the resident. The resident stated the hand splints had helped with her hands and that she applied them herself. The resident reported pain in her hands, particularly the left hand, had difficulty moving her hand at times due to pain, difficulty opening items such as a bag of chips, and difficulty completing some dressing tasks. The resident also stated she did not recall being asked about her care plan. Further observation revealed the resident was not wearing the ordered bilateral hand splints. An interview was conducted on July 1, 2026, at 2:29 p.m. with Certified Nursing Assistant (CNA/Staff #4). Staff #4 stated staff generally become aware of residents' ROM needs and devices by asking the nurse or observing residents with equipment. She stated she was not aware whether Resident #27's bilateral hand splints were part of the resident's daily care routine. An interview was conducted on July 1, 2026, at 2:35 p.m. with Registered Nurse (RN/Staff #19). While reviewing the resident's electronic health record (EHR), Staff #19 stated there was a physician's order for bilateral hand splints. After reviewing the resident's care plan, the RN stated he did not find any reference to the bilateral hand splints and stated the intervention should have been included in the care plan. He further stated that if a resident has an order for a splint or brace, it should be reflected in the care plan. He stated the risk of not including the order in the care plan could result in the intervention being missed. An interview was conducted on July 1, 2026, at 3:09 p.m. with the Director of Nursing (DON/Staff #40). The DON stated therapy typically evaluates residents and communicates recommendations to nursing. During a review of the resident's EHR, she further stated there was an order for bilateral hand splints dated March 29, 2025, and stated the intervention should have been included in the resident's care plan. The DON stated staff, including nursing, social services, dietary, and CNAs, have access to the care plan. She stated the risks of omission of the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	splint intervention could result in missed ROM interventions and failure to monitor the resident's skin while using the splints. On July 2, 2026, the facility provided documentation and in-service records of staff education on revising care plans. The subject was Care planning adaptive devices, all medical equipment, other DME accurately by reviewing order listing daily, dated July 1, 2026 for 35 minutes. A review of the facility policy titled Care Plans, Comprehensive Person-Centered, revised December 2016, states that the policy outlines a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, The facility failed to implement infection prevention and environmental cleaning practices consistent with facility policy and accepted infection control standards by reusing contaminated environmental cleaning equipment between resident care areas, storing reusable cleaning tools submerged in disinfectant solution, using contaminated equipment after cleaning areas contaminated with feces, and allowing contaminated equipment to contact resident environments and personal belongings for 2 residents (#14 and #22) out of 5 sampled residents. The facility census was 58. The deficient practice had the potential to contribute to environmental cross-contamination and transmission of infectious organisms, including MDROs, among residents. Findings Include: Record review revealed Resident #14 was initially admitted on [DATE], and readmitted on [DATE], with diagnoses including cellulitis of the left lower extremity, chronic systolic congestive heart failure, type 2 diabetes mellitus, extended-spectrum beta-lactamase (ESBL) multidrug-resistant organism (MDRO), stage 2 chronic kidney disease, and an open wound of the right lower leg. Physician orders dated January 14, 2026, directed staff to implement Enhanced Barrier Precautions (EBP) during high-contact resident care activities due to chronic wounds. Record review revealed Resident #22 was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, stage 3A chronic kidney disease, and orthostatic hypotension. Physician orders dated June 29, 2026, directed staff to provide wound care for a wound located on the dorsum (top) of the left hand. Record review further revealed Resident #22 had an active physician order dated June 29, 2026, for treatment of a wound to the left hand. On July 1, 2026, at approximately 1:37 p.m., a room cleaning observation was conducted with Housekeeping Manager (Staff #88) and Housekeeper (Staff #80) in the shared bathroom and resident rooms occupied by Residents #14 and #22. An EBP sign was posted outside the shared entrance. During the observation, Staff #80 discovered extensive fecal contamination on the shower walls and floor and soiled linens in the bathroom. Nursing staff removed the soiled linens and the bulk of the fecal matter; however, visible fecal residue remained on the shower floor before environmental cleaning began. Staff #80 sprayed the contaminated shower with a cleaning solution identified as Apple [NAME] and used a broom to scrub the shower floor. The same broom was later used to sweep Resident #14's room, Resident #22's room, and the shared hallway without cleaning or replacing the broom head. During sweeping, the broom contacted Resident #14's personal belongings, including a belt and chess pieces located on the floor. During the same observation, Staff #80 used a gallon container labeled Apple [NAME] that contained cleaning solution in which a reusable toilet brush and multiple reusable scrub pads were stored submerged together. Visible debris was present in the solution. Staff #80 removed a scrub pad from the container, cleaned the shower walls, returned the used scrub pad to the solution, then removed the toilet brush from the same container to clean the toilet before placing the contaminated brush back into the solution. Staff #88 subsequently mopped Resident #14's room, Resident #22's room, the shared bathroom, and the hallway using the same mop before removing the mop head at the completion of cleaning. On July 2, 2026, at approximately 10:04 a.m., Staff #80 was again observed with the same style container of Apple [NAME] cleaning solution containing a reusable toilet brush and reusable scrub pads submerged in the solution with visible debris. During the observation, Dietary Director (Staff #57) instructed Staff #80 to discard the solution, which was poured onto the gravel outside the building. The facility administrator (Staff #43) was notified on July 2, 2026, at approximately 10:07 a.m., of the infection control concerns identified during the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation. He stated the affected rooms would be re-cleaned. During an interview on July 1, 2026, Staff #80 stated she routinely stored the reusable toilet brush and scrub pads submerged in the Apple [NAME] solution since beginning employment at the facility, reused the toilet brush and scrub pads between resident rooms, believed the practice complied with facility policy, and did not believe it posed an infection control risk because the cleaning solution was strong. During an interview on July 2, 2026, the facility administrator (Staff #43) stated storing cleaning tools in disinfectant solution was not consistent with facility policy because it could contaminate the cleaning solution and contribute to cross-contamination and transmission of infection. During an interview on July 2, 2026, Dietary Director (Staff #57) and Housekeeping Manager (Staff #88) confirmed facility policy required cleaning tools to be stored separately from cleaning chemicals, that disinfectant solutions were to remain uncontaminated, and that using a broom to agitate cleaning solution and then clean multiple resident care areas without changing the broom head was not consistent with facility expectations or policy because it increased the risk of cross-contamination. Review of the facility policy, Enhanced Barrier Precaution (Revised December 2024), stated Enhanced Barrier Precautions are intended to reduce transmission of multidrug-resistant organisms during high-contact resident care activities and identified wound drainage and fecal contamination as conditions that increase the potential for environmental contamination and pathogen transmission. Review of the facility policy, Cleaning and Disinfection of Environmental Surfaces (Revised August 2019), required environmental surfaces to be cleaned and disinfected according to CDC recommendations, visible blood and body fluids to be removed using disposable materials, contaminated materials to be discarded appropriately, cleaning solutions to be replaced with fresh solution frequently, and manufacturer instructions to be followed when using disinfectants.		