

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2024
NAME OF PROVIDER OR SUPPLIER  Arizona State Veteran Home-Phx		STREET ADDRESS, CITY, STATE, ZIP CODE  4141 North S Herrera Way Phoenix, AZ 85012	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40581</p> <p>Based on clinical record review, staff interviews and review of facility documentation, policy and procedure, the facility failed to ensure one resident (#7) was treated with dignity and respect by another resident (#25). The deficient practice could impact residents' emotional and psychological wellbeing.</p> <p>Findings include:</p> <ul style="list-style-type: none"> <li>-Resident #7 was admitted on [DATE] with diagnoses of quadriplegia, chronic kidney disease, and Type II Diabetes.</li> </ul> <p>The minimum data set (MDS) assessment dated [DATE] included brief interview for mental status (BIMS) score of 15 indicating the resident was cognitively intact.</p> <p>Review of behavior analysis report revealed that resident #7 did not exhibit any behaviors during the month of April 2024.</p> <ul style="list-style-type: none"> <li>-Resident #25 was admitted on [DATE] with diagnoses of Alzheimer's disease, unspecified dementia, unspecified severity, with other behavioral disturbance.</li> </ul> <p>The care plan dated April 6, 2024 revealed that the resident had socially inappropriate/disruptive behavioral symptoms as evidenced by verbal altercations with staff; and that, the resident will be with a two-person approach. The care plan also included that a verbal altercation occurred with peer on April 6, 2024. Interventions included to redirect the resident when resident was agitated; and, if this was unsuccessful, separate the resident from anyone whom the resident was agitated with; if the resident continued to be agitated and exhibiting threatening behaviors notify the supervisor and the Assistant Director of Nursing (ADON).</p> <p>Review of the behavior analysis report revealed that on April 6, 2024, resident #25 yelled at another resident (#7) and called him nigger and little boy.</p> <p>A progress note dated April 8, 2024 revealed that resident #25 had a verbal altercation with another resident (#7). Per the documentation, resident #25 was redirected right away, there were no further altercation or behavior noted and staff will continue to monitor.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on April 22, 2024 at 2:37 p.m. with resident #7 who stated that resident #25 had told him to shut up in front of everyone during a meeting on April 5, 2024. Resident #7 also stated that on April 6, 2024, he tried to talk it out with resident #25 who kept calling him boy. He stated that resident #25 had called him boy before and he had asked him not to do it. Further, resident #7 said that resident #25 knows that this was a derogatory remark because he (referring to resident #7) was black and it made him mad and upset.</p> <p>An interview was conducted on April 22, 2024 at 2:55 p.m. with a registered nurse (RN/staff #5) who stated resident #25 was yelling, get this boy out of here and flailing his arms around; and that, resident #7 was calm and kept asking resident #25 to stop calling him boy. The RN said that resident #25 had called resident #7 boy on prior occasions. The RN stated that back in the day, the term, boy was derogatory and disrespectful.</p> <p>An interview was conducted with resident #25 on April 22, 2024 at 3:10 p.m. with resident #25, who stated that he did tell resident #7 to shut up during a meeting because resident #7 kept interrupting him, but he did not call resident #7 boy. He stated that resident #7 threatened to beat him up if he told him to shut up again. Resident #25 said that he does not take that from anyone.</p> <p>On April 22, 2024 at 3:24 p.m. an interview was conducted with the Social Services Supervisor (staff #1) who stated that resident #25 called resident #7 boy multiple times and was asked to stop.</p> <p>The facility's policy, Residents Rights states that the resident has the right to be treated with consideration, respect, and full recognition of his or her dignity and individuality.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40581</p> <p>Based on clinical record review, staff interviews, and the facility policy and procedures, the facility failed to ensure a thorough investigation for an allegation of sexual abuse for one resident (#12) was completed. The deficient practice could result in residents not protected from further abuse and appropriate corrective action not taken.</p> <p>Findings include:</p> <p>Resident #12 was admitted on [DATE] with diagnoses of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side.</p> <p>The cognitive loss/dementia care plan dated February 20, 2024 revealed the resident was alert and oriented to person and place and semi-oriented to time; and that, the brief interview for mental status (BIMS) assessment indicated that the resident had a slight cognitive deficit in short-term memory, which may be tied-in with having a diagnosis of cerebral infarction.</p> <p>A progress note dated April 10, 2024 at 7:13 p.m. revealed that during a conversation, the veteran reported allegations of abuse to a staff who reported this allegation to the day shift nurse and the evening shift nurse. The documentation also included that the local police, family and responsible party were notified.</p> <p>The report the facility submitted to Adult Protective Services (APS) dated April 10, 2024 revealed that the social worker reported the date and time of the incident was on April 6, 2024 at 12:00 a.m.; and, the incident happened during the evening shift between 6:00 p.m. and 6:30 a.m. Per the documentation, the resident reported that he was accosted by one male staff and one female staff member at the same time; and that, both staff were verbally aggressive towards him. Further, the documentation included that the resident also reported physical abuse and his physical space was invaded but did not elaborate. It also included that the resident did not know the names of the two staff involved but had identified them as staff members of the evening shift at the facility last Saturday.</p> <p>Review of the 5-day written investigation dated April 15, 2024 revealed that during a conversation with a staff, resident #12 reported that two staff members approached the resident, manhandled him and tried to take his watch. The report included that there was no alleged perpetrator identified; and that, the incident was reported to the administrator, Director of Nursing (DON), State Agency (SA), APS, Ombudsman, local police and the physician. The investigation did not include staff interviews conducted, interviews of other residents to whom the accused employee provides care or services, witness statements (if any), results of the investigation as well as corrective actions taken.</p> <p>The investigation included an interview with resident #12.</p> <p>There was no evidence found in the facility documentation that the allegation of sexual abuse for resident #12 was thoroughly investigated.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on April 22, 2024 at approximately 12:50 p.m. with the Social Services Supervisor (staff #1), who stated that the 5-day investigation should have included resident interviews other than resident #12; however, she stated that she does not know whether these interviews were conducted. Further, staff #1 stated that the report should also include staff interviews.</p> <p>During the survey, the Administrator and Director of Nursing were not available for interview.</p> <p>The facility policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation dated September 2022 states that all allegations are thoroughly investigated. The individual conducting the investigation as a minimum:</p> <ul style="list-style-type: none"> <li>-Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;</li> <li>-Interviews any witnesses to the incident;</li> <li>-Interviews other residents to whom the accused employee provides care or services; and,</li> <li>-Documents the investigation completely and thoroughly.</li> </ul>		