STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that adequate supervision was provided to prevent resident (#55) to resident (#12) abuse. The deficient practice could result in residents harming each other physically and emotionally. Findings include: Resident #12 was admitted on [DATE] to the facility on with diagnoses that included major depressive disorder, mood disorder due to known physiological condition with depressive features, and an adjustment disorder. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 8 indicating a moderate cognitive impairment. A care plan dated November 21, 2022 revealed that the resident is receiving a mood stabilizer medication for a diagnosis of adjustment disorder with mixed anxiety and depressed mood disorder, depression, major depressive disorder, delirium, anxiety disorder, and other signs and symptoms involving cognitive functions following cerebral infarction. Interventions included to monitor for mood or behavior changes that improve or worsen and notify the medical practitioner. A progress note dated September 5, 2024 by a recreational therapist revealed that she walked into the dining room to see two residents next to each other shouting. The therapist separated the residents and asked them what had happened and both residents said, he hit me. A progress note dated September 5, 2024 that the nurse was called into the dining room by the recreational therapist due to an altercation between two veterans. The therapist stated that she stepped out of the dining room and when she returned she saw two residents arguing and shouting, shut up, he hit me. The therapist stated that resident #55 was behind resident #12 and she separated them. Resident #55 stated that resident #12 wouldn't shut up. Resident #12 stated that resident #55 had hit him. Resident #12 was assessed and had no redness on either arm. The care plan dated September 5, 2024 that the resident has socially inappropriate/disruptive behavioral symptoms as evidenced by an altercation with another resident. Interventions included to allow distance in seating other residents around the resident and place the resident in a specially designed therapeutic unit. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #55 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included a psychotic disorder with delusions, adjustment disorder with mixed disturbance of emotions and conduct, and unspecified dementia without behavioral disturbance, mood disturbance, and anxiety. A care plan dated October 27, 2020 revealed that the resident has a history of socially inappropriate/disruptive behavioral symptoms toward other residents, wandering, and need for continuous supervision. The resident has a diagnoses of Alzheimer's disease, adjustment disorder, dementia, psychotic disorder as evidenced by: -March 5, 2019, the resident grabbed another resident by the back of the hooded jacket and pulled. -June 24, 2019, the resident had a verbal altercation with another resident. -September 1, 2021, during the review period, the resident had a verbal altercation with another resident. The resident has a history of disruptive behaviors. -December 18, 2023, the resident pulled another resident in his wheelchair away from the table because the other resident was banging on the table and making noise. -September 5, 2024, the resident had an altercation with another resident. Interventions included to assess whether the behavior endangers the resident and/or others. When behaviors occur, provide redirection to divert the resident from the object/peer/staff that may be causing the frustration/behavior. The care plan dated June 11, 2024 revealed that the resident is receiving psychotropic medication related to diagnosis of psychotic disorder with delusions caused by a known physiological condition. Interventions included to monitor/record occurrence of target behavior symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, and document as per facility protocol. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 5 indicating the resident had a severe cognitive impairment. The physician's note dated August 6, 2024 revealed that resident #55 was seen for his 60-day regulatory visit. The resident was noted to have increased aggression over the last 6 weeks. An interview was conducted on September 23, 2024 at 3:51 p.m. with the Administrator (staff #1), who stated that resident #55 grabbed resident #12 by the forearm and was telling him to stop yelling. He stated that resident #12 pulled away and did not have any injuries. He stated that he did not substantiate abuse because this was a one-time thing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on September 23, 2024 at 4:46 p.m. with the Therapeutic Program Director/Recreational Therapist II (staff #64), who stated that she was walking a resident into the dining room for dinner around 4:30 p.m. and heard yelling as soon as she entered the room. She stated that both residents (#12 and #55) were yelling, He hit me. Let me at him and she separated them. She stated that resident #12 was in his wheelchair and was facing the table and resident #55 was in his wheelchair behind resident #12 and was facing towards resident #12. She stated that there is supposed to be staff monitoring the dining room during meal time and had to find staff to help. When she returned to the dining room, there was a CNA present and there was a nurse following behind her. An interview was conducted on September 23, 2024 at 5:10 p.m. with the Director of Nursing (DON/staff #3), who stated that there is supposed to be a staff in the dining room supervising the residents, especially, on the unit where resident #12 and #55 reside because the residents have dementia and behaviors. He stated that the unit used to be a closed unit, but was opened to create more space. He stated that he reviewed the tape and could see resident #55 grab resident #12's left arm, but there was no sound, so he doesn't know if the residents said anything. He stated that he did not see staff in the dining room when he reviewed the tape, but there was not a full view of the room. The facility policy, Safety and Supervision of Residents states that the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.