

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 12/10/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</p> <p>Based on review of the clinical record, staff interviews, facility documentation, policy and procedure, the facility failed to ensure the care plan was implemented related for fall prevention for one resident's (#2). The deficient practice could result in residents sustaining falls with injuries that may be preventable.</p> <p>Findings include:</p> <p>Resident #2 was admitted on [DATE] with diagnoses of multiple sclerosis, mood disorder due to known physiological condition with depressive features, adjustment disorder, unspecified, weakness.</p> <p>A review of the quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview Of Mental Status) score of 13 indicating resident's cognition was intact. The assessment also included that the resident required extensive assistance of 2 for bed mobility and transfers. Further review of the MDS revealed resident had lower extremity impairment on both sides.</p> <p>Review of the progress notes dated September 9, 2023 revealed resident was found on the floor close to his bed and his head facing the door. Resident stated I was trying to turn to my right side and slide to the floor. Per the progress note the resident complained of pain to his right hip. Resident was sent to the hospital a CT revealed a non-displaced fracture of the right posterior acetabulum and no surgical interventions required.</p> <p>Review of the facility reportable event record dated September 28, 2023 revealed the fall risk care plan had been updated to include new interventions that included; maintain bed in low position while in bed, place floor mat on right side of bed while in bed-remove when out of bed, provide 1/4 side rail on right side of bed to facilitate bed mobility, turning and positioning, position call light above resident's right shoulder, anticipate needs.</p> <p>The comprehensive care plan last reviewed/revised on October 25, 2024 included that the resident was at risk for falls related to altered mobility, diagnosis of multiple sclerosis. The care plan that the resident had following incidents of fall:</p> <ul style="list-style-type: none"> - 02/18/23 resident had a witnessed fall due to slide out of w/c (Wheelchair) - 05/08/23 resident had a witnessed fall. <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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 09/23/2023 resident had an unwitnessed fall with injury, resident slide out of bed while repositioning self - non-displaced fracture of the right posterior acetabulum-no surgical intervention-readmission s/p hospitalization on [DATE]: no fracture identified.</p> <p>- 09/29/23 resident had an unwitnessed fall while traveling independently.</p> <p>- 03/17/24 resident had an unwitnessed fall from bed with no injuries.</p> <p>- 10/28/2024 resident had an unwitnessed fall while out on Independent Travel pass-abrasions to right elbow and right knee and small laceration to right inner thigh.</p> <p>An observation was conducted on December 9, 2024 at 1:38 P.M of resident #2 while in bed. Resident was observed in bed with bed in the high position. Floor mat was observed leaning against the wall near the resident's bed.</p> <p>An interview was conducted with resident #2 on December 9, 2024 at 1:38 p.m. Resident #2 stated he had been placed in bed with the Hoyer lift and staff had left the bed in the high position. The resident stated he did not change the position of the bed.</p> <p>An interview was conducted on December 9, 2024 at 1:40 p.m. with a CNA (Certified Nursing Assistant/ staff #28) and CNA (staff # 14) who stated they had placed resident #2 in bed, but were unaware that the bed position should be lowered, then stated the resident must have changed his bed position.</p> <p>An interview was conducted on December 9, 2024 at 1:42 p.m. with another CNA (staff #9) who stated she is the assigned CNA for resident #2. She stated CNA's #28 and #14 had placed resident #2 in bed for her and should have placed the resident's bed in the low position and floor mat on the floor due to the resident being a fall risk.</p> <p>CNA# 9 then placed the resident #2's bed in the low position and placed the floor mat on the right side of the resident's bed and ensured the residents call light was within reach. CNA#9 stated the risks of not following the care plan is that the resident could get hurt and sent to the hospital if he were to hit his head.</p> <p>An interview was conducted on December 9, 2024 at 1:46 p.m. with a registered nurse supervisor (RN/staff #3) who stated resident #2 is identified as a fall risk and preventive measures are in place which include an electric wheel chair for indoor use only with a seat belt, floor mat when in bed, call light in place on right side due to left sided weakness, 1/4 side rail, proper footwear , properly positioned while in wheelchair, low position for bed and a don't fall, Call sign in his room. Staff #3 stated the CNA's have access to the resident's plan of care on the matrix, census sheet received during report, huddles, and the expectation is that they are to always ask staff, their peers, supervisor if they are unsure of the resident's POC (plan of care). Staff #3 stated the risks are any injury to the resident or a re-current fall.</p> <p>An interview was conducted on December 9, 2024 at 2:15 p.m. with the DON (Director of Nursing/Staff #5) who stated that there was a POC task for low bed and floor mats for resident #2 due to high risk for falls. The DON said that the risk of not placing the bed in low position and the floor mat is a potential injury if the resident should fall.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Care Plans-Baseline with a revision date of May 2024 revealed that the baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.</p> <p>The facility policy titled Falls and Fall Risk, managing states based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize the complications from falling.</p>		