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	01/14/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50553 Based on clinical record reviews, staff and resident interviews, facility documentation, and policy and procedures, the facility failed to ensure residents (#3 and #4) were free from abuse. The deficient practice could lead to further resident to resident abuse. Findings include: -Regarding Resident #3 Resident #3 was admitted to the facility on [DATE] with diagnoses including Neurocognitive disorder with Lewy bodies, encephalopathy, and post-traumatic stress disorder. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the careplan revealed, initiated on July 19, 2023, a problem that indicated that the resident had socially inappropriate and disruptive behavioral symptoms. This entry addressed that the resident is occasionally aggressive towards staff. The entry was revised on January 4, 2025 to include that the resident had shown sexually inappropriate behaviors; and that, the resident had a peer to peer physical altercation. An approach was added on January 4, 2025 to provide a two staff approach with care. Another approach was initiated on January 5, 2025 that indicated that the resident's room was moved. -Regarding Resident #4 Resident #4 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, mild cognitive impairment of uncertain or unknown etiology, and dementia. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 08, which indicated moderate cognitive impairment. Review of the careplan revealed that the resident had socially inappropriate and disruptive behavioral symptoms, as evidenced by a physical altercation with a peer on January 4, 2025. (continued on next page)

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 - Few	Review of the nursing progress notes for Resident #3 and Resident #4 revealed that on January 4, 2025, at approximately 5:30PM, the two residents were observed sitting next to each other, when they both raised their fists to each other. The CNA (Certified Nursing Assistant) on the unit then intervened, separating the residents. When questioned, both residents confirmed they had hit each other, but both residents claimed that the other had struck first. The initial contact was unwitnessed by staff. An interview was conducted on January 14, 2025 at 11:14AM with a CNA (Staff #15) who stated that Resident #3 normally has sundowning behaviors, but prior to the altercation, with Resident #4, he was showing behaviors at different times of day than normal. She stated that the resident was speaking loudly to some of the residents, so she had to move him away from the other residents. The CNA stated that she did not witness the altercation with Resident #4, but Resident #3 had claimed that Resident #4 hit him. She claimed that no one witnessed the altercation, but confirmed that cameras may have caught the incident. The CNA stated that Resident #3 was upset all day following the altercation, but both residents did not recall the incident the next day. An interview was conducted on January 14, 2025 at 11:24AM with another CNA (Staff #24) who had witnessed the altercation between Resident #3 and Resident #4. She claimed that she did not see the residents hit each other, but had seen both residents sat by each other in their wheelchairs with their fists raised up towards each other. She had immediately separated the residents, and Resident #3 kept saying that Resident #4 had hit him. The CNA explained that Resident #3 can be aggressive, and tends to sundown toward the night time. He can sometimes initiate fights with other veterans and has increased behaviors at night time. She claimed that Resident #4 had never shown any aggressive behaviors prior to this altercation. She claimed that the two residents have never had prior issues together, and often sat together for meals. An interview was conducted on January 14, 2025 at 11:50PM with a Registered Nurse (RN/Staff #22) who stated that she did not see the altercation, but the CNA had seen the residents with fists up and had separated them. The RN stated that no one saw any contact being made and that there was no yelling prior to seeing the residents with raised fists. She stated that after separating the residents, Resident #3 claimed Resident #4 had hit him. Resident #4 confirmed that he had hit Resident #3, but only because he claims he was hit first. The RN explained that skin assessments were done and no marks or bruising was found. She also stated that Resident #3 stated he wanted to file a complaint. The RN stated that she believed that Resident #3 had a history of inciting others. She also explained that following the altercation, both residents' careplans were updated, their rooms were separated, and that they are being monitored closely. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 14, 2025 at 12:23PM with the Assistant Director of Nursing (ADON/Staff #7), who idenfitied verbal threats, physical touching, and stealing to be examples of abuse. She explained that the altercation between Resident #3 and Resident #4 occurred on January 4, 2025 around 5:30PM by the fish tank near the nursing station. She explained that the CNA had noticed the two residents with their arms up and had separated them. The ADON stated that Resident #3 claimed Resident #4 hit him, and Resident #4 confirmed he had hit him because Resident #3 had hit him first. She explained that both residents have severe dementia. She also stated that Resident #3 sometimes had behaviors, describing him as hard to re-direct, fixated, and sometimes will kick and hit, normally towards staff. She also stated that Resident #4 had not previously shown any behaviors. The ADON explained that following the incident, the two residents rooms were moved further apart, their dining room tables were moved, urine cultures were obtained, which showed that both residents had urinary tract infections (UTIs), and Resident #3's antipsychotic medication was increased. The camera footage from the altercation between Resident #3 and Resident #4 was reviewed on January 14, 2025 at 12:45PM with the Executive Director (ED/Staff #44). The ED stated that the footage was from January 4, 2025 at approximately 5:30PM. The camera captured the floor space by the nursing station, and the camera was positioned over the large fish tank near the wall. The ED was able to identify the two visible residents as Resident #3 and Resident #4. In the footage, it was observed that Resident #3 was in his wheelchair, near the center of the room. Resident #4 sat in his wheelchair in front of the fish tank. In the footage, Resident #3 appears to slowly roll his wheelchair backward to near where Resident #4 was seated, almost into him. Resident #3 continued to roll his wheelchair, moving it to where his chair was positioned almost beside Resident #4's wheelchair, on the left side. At that point, it can be seen that both residents raise their arms suddenly, forearm to forearm. The two residents' arms can be seen pushing against eachother, swaying under the struggle. It could not be determined what caused the two residents to suddenly raise their arms to eachother. The CNA could be seen shortly after rushing over and removing the residents away from each other. Interview was conducted on January 14, 2025 at approximately 12:48PM with the ED (Staff #44), who explained the camera footage in his perspective. The ED explained that upon watching the footage, it can be seen that Resident #3 was backing up his wheelchair, and was backing into Resident #4. He stated that it appeared that the residents were talking to eachother. As Resident #3 was backing up the wheelchair, the ED explained that Resident #3 was backing up further to talk to Resident #4. The ED stated that Resident #4 becomes out of sight at this point. He then explained that he saw what he described as hand-fighting, indicating no solid punches were thrown. He stated that it appeared that Resident #3 raised his arms, attempted to hit Resident #4, who then grabbed Resident #3's hand. He stated that the residents were hand-fighting when the CNA separated the residents. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropiration Prevention Program, indicated that residents have the right to be free from abuse, including freedom from verbal, mental, sexual or physical abuse.