

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 02/19/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</p> <p>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to provide adequate supervision which resulted in the elopement of one resident (#22). The deficient practice could result in residents being physically and/or psychosocially harmed.</p> <p>Findings include:</p> <p>Resident #22 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease without dyskinesia, unspecified dementia, and a cognitive communication deficit.</p> <p>Review of the brief interview for mental status (BIMS) dated January 10, 2025 revealed, that the resident is rarely understood; and that, the interview could not be completed.</p> <p>The care plan dated February 16, 2025 revealed that the resident demonstrated unsafe travel outside the facility without a responsible party or proper authorization. An elopement dated February 16, 2025. Interventions included to apply Wander-guard to reduce risk of elopement and hourly checks.</p> <p>Review of the order summary revealed an order:</p> <ul style="list-style-type: none"> -March 22, 2024, the resident may go out on pass with a responsible party with medications. -February 16, 2025, nursing to check Wanderguard is in place every shift: 6:00 a.m to 18:00 p.m. and 10:00 p.m. to 6:00 a.m. -February 16, 2025, alert charting - elopement episode every shift: 6:00 a.m to 18:00 p.m. and 10:00 p.m. to 6:00 a.m. <p>The Independent Travel-Admission form dated January 3, 2025 revealed that resident #22 is able to make self understood, understands others with clear comprehension, and is not interested in independent travel because the resident goes out with family only.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated February 16, 2025 revealed that the Social Services Manager (staff #6) has seen the resident at the cross roads propelling himself to the gas station to buy a mocha coffee. Staff #6 noted the resident and assisted the resident back into the facility. A head to toe assessment was completed by a supervisor. The resident stated that he wanted to buy a mocha coffee at the gas station. The resident eloped from the facility. The resident was last observed by staff at 1:30 p.m. Per the security guard, he signed out of the facility at 1:30 p.m. and then the resident was assisted back into the facility by staff #6 at 1:40 p.m.</p> <p>An interview was conducted on February 18, 2025 at 3:08 p.m. with the Social Services Manager (staff #6), who stated that resident #22 can't go out except with family per the physician order. Staff #6 stated that she was in her car and saw the resident was in his wheelchair approximately fifty feet away from a traffic intersection. She went after the resident and asked him what he was doing and resident stated that his wife was supposed to be here and she usually gets his mocha drink, so he was going to get it himself. Staff #6 stated that the resident's wife was not supposed to visit the resident on this day, and that, she assisted the resident with returning to the facility and got him the drink. She stated that it is the guard's responsibility to monitor the residents on the front patio and had access to the video cameras to monitor the residents, but stated that he didn't know how to work them; but that, he also stated that he didn't know that the resident was not allowed to leave the facility by himself. Staff #6 stated that the resident was at risk of not making it across the busy intersection on the green light.</p> <p>An interview was conducted on February 19, 2025 at 12:57 p.m. with the Director of Nursing (DON/staff #1), who stated the doctor determines if a resident is able to go out independently, which is done on a quarterly basis. The facility does the assessment and the doctor signs it. DON stated that it is his expectation that the receptionist and the guard refer to the independent travel book to verify is a resident can go out independently. He stated that the security guard is supposed to watch the video cameras to monitor the residents on the front patio area. He stated that resident #22 was at risk because he was in a manual wheelchair; and that, he is not sure that the resident would have been able to find his way back to the facility.</p> <p>The facility policy, Emergency Procedure - Missing Resident states that resident elopement resulting in a missing resident is considered a facility emergency. Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety.</p>		