

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 04/24/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff, resident and family interviews, and policies and procedures, the facility failed to ensure that allegations of abuse, neglect, and/or misappropriation of resident property were thoroughly investigated for residents (#3, #10, #11, #20, #30, #54 #63, #129, #146, #98, #14). The deficient practice could result in violations towards residents without being identified or without appropriate steps being taken to protect residents.</p> <p>Findings include:</p> <p>-Resident #63 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder with Lewy bodies, cognitive communication deficit, and dementia.</p> <p>Review of the care plan revealed a problem focus, initiated November 15, 2019, that indicated that the resident was alert and oriented x2-3 and was able to make needs known. This problem also indicated that the resident had a diagnosis of dementia with behavioral disturbance, and the resident's BIMS score may fluctuate.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment.</p> <p>Review of the progress notes revealed that on December 20, 2022, the resident was noted with increased behaviors and aggression toward staff. There was no evidence found in the progress notes that the Resident #20 made any abuse allegations toward staff on December 20, 2022.</p> <p>Review of the facility investigative report revealed that on December 20, 2022, Resident #63 was overheard on the phone alleging that a male Certified Nursing Assistant (CNA) threw him down the hall. The facility investigation indicated that following the event, Resident #63 was interviewed and his story changed multiple times. There was no evidence of interviews with Resident #63 in the facility investigation .</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Attached to the facility investigation were two interviews, one of which was from a Licensed Practical Nurse (LPN/Staff #98), which revealed that Resident #63's family had called to talk to him on the phone. The statement revealed that during the conversation, Resident #63 alleged that a man dragged him out and beat him up. The statement revealed that the LPN asked if this occurred on this date, and Resident #63 confirmed that it did. The LPN at this time notified the ADON and the resident's family. The LPN revealed that the family stated that she would take the allegation with a grain of salt, as the resident had a history of making such allegations at home. The investigation did not indicate who was the male CNA working the shift, or any evidence that this staff member was interviewed for a statement. An additional attached statement was from an LPN (Staff #100), who indicated that she did not see anything, but overheard Resident #63 calling a male staff member profanities multiple times. The statement gave the first name of a male staff member. Based off of this information and review of the staff assignments from December 20, 2022, it was revealed that this male staff member was likely Staff #103.</p> <p>Further review of the facility investigative report revealed that video footage was reviewed with no incidents being observed for Resident #63. The investigation also indicated that ten residents and ten staff were interviewed with no findings. There was no evidence found that any residents were interviewed, and the only two staff statements found were from the LPNs. There was no statement found from the alleged perpetrator.</p> <p>The facility investigative report also indicated that the resident's care plan would be edited to include that the resident should be a two-person approach.</p> <p>Review of Resident #63's care plan for December 2022 revealed no evidence that the resident was supposed to be a two-person approach. Further review of the care plan revealed that a two-person approach was initiated later as an intervention on January 4, 2025.</p> <p>Review of the charted observations revealed no evidence that a skin assessment was completed on December 20, 2022, following the abuse allegation.</p> <p>Interview was conducted on April 23, 2025 at 3:10PM with a CNA (Staff #103), who confirmed he was familiar with Resident #63, and stated that the resident was really confused and verbally aggressive. The CNA confirmed that he was aware that Resident #63 had made an allegation against him a couple of years ago. The CNA stated that Resident #63 had alleged that he had beat him up and thrown him down the hall. The CNA stated that he did not do these things, and that he had never witnessed any staff be abusive towards residents. The CNA stated that the resident had been upset with him that night, as the CNA had placed him at the nurses' station because the resident was attempting to ambulate and almost falling. The CNA recalled that Resident #63 was upset about this and stated that he would report the CNA.</p> <p>-Resident #20 was admitted to the facility on [DATE] with diagnoses that included fibromyalgia and major depressive disorder.</p> <p>Review of the MDS dated [DATE] revealed a BIMS score of 12, which indicated resident was moderately cognitively impaired.</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 - Some</p>	<p>Review of Resident #20's care plan initiated on February 16, 2022, revealed that the resident had socially inappropriate behavioral symptoms, evidenced by false accusations toward staff. Interventions included using a 2 person assist for all personal care, and reporting and investigating allegations per facility protocol.</p> <p>A review of the facility reportable investigation revealed that on September 21, 2022, Resident #20 alleged abuse against a male staff member who had worked with her on either September 18, 2022 or September 19, 2022. The resident described that the staff member was an African American male Certified Nursing Assistant (CNA) with a thick accent and was approximately five foot and eleven inches tall. Staff identified three potential staff who had fit the description. Upon being shown images of the males CNAs working these nights, Resident #20 failed to identify any of the staff as the perpetrator.</p> <p>Further review of the facility investigation revealed a statement from the Interim Director of Nursing (DON), dated September 23, 2022, which revealed that the administrator on DON had spoken to Resident #20 about her allegation. In this interaction, the resident stated that she had received ADL care from a male CNA who was very physical and caused her pain. She gave the same description of the alleged perpetrator. The statement then detailed that two of the three staff that fit the description were placed on administrative leave, while the third staff member was brought to the resident, who stated that he was not the alleged perpetrator.</p> <p>Further review of the facility investigation revealed a statement from a Registered Nurse (RN/Staff #109), dated September 22, 2022, which revealed that this RN had completed a skin assessment on Resident #20 was completed with no new skin concerns noted. There were no other statements or interviews with other staff, including any of the potential perpetrators, included in the facility investigation.</p> <p>The facility investigation included an identification badge for one of the staff members that had matched Resident #20's description. No statement from this staff member was included in the investigation. Additionally, the investigation did not reveal the identities of the two other staff members who had fit the description or statements from these staff.</p> <p>-Resident #11 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease without dyskinesia, anxiety disorder, and atrial fibrillation.</p> <p>Review of the MDS dated [DATE] revealed a BIMS score of 14, which indicated that the resident was cognitively intact.</p> <p>Review of the resident's inventory sheet, dated December 3, 2024, revealed that the resident had brought multiple items into the facility, including: seven blouses, five pants, three shorts, three socks and two compression socks, two t-shirts, and four rings. The inventory sheet did not provide details of the appearance of these items.</p> <p>Review of the nursing progress notes revealed a nursing note dated December 7, 2024, which revealed that Resident #11 had reported that he was missing clothes, including 2 shirts and compression stockings. The resident was noted to be upset with the laundry attendant, refusing to allow the laundry staff to take any more of his clothing.</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 - Some</p>	<p>Further review of the progress notes revealed a note dated December 10, 2024, which revealed that social services spoke with Resident #11 regarding his missing items. The resident again reported the same details of the missing clothing and also reported missing two rings. The note revealed that staff planned to speak with the director of housekeeping about the missing clothing, and staff planned to check the resident's lockbox for the missing rings.</p> <p>Review of the facility investigative report revealed that following Resident #11 reporting the rings and clothing missing, the facility notified Resident #11's family, who suggested that the rings may be in the resident's locked lockbox. The report revealed that the lockbox was checked but no rings were located. This report also revealed that the resident stated he was missing his clothing after housekeeping took the clothing for labeling. Review of the investigative report revealed no evidence that housekeeping staff were interviewed about this allegation, or that the laundry facilities were searched for the missing items. The facility investigative report also revealed no evidence that any staff or other residents were interviewed for this investigation.</p> <p>Interview was conducted on April 17, 2025 at 12:13PM with a Registered Nurse (RN/Staff #12), who explained that items are inventoried on admission. She stated that staff would document what items and how many of each item the resident comes in with. She also stated that she would describe the items on the inventory sheet, such as describing what types of stones are on rings. The RN also stated that this inventory sheet was supposed to be updated if new items are brought in, but family does not always tell staff what new items are brought. The RN reported that the process for missing items would be to first get a history in an attempt to find where the items were last seen. She reported that staff then searches for the items with permission. The RN stated that the missing items are always reported to the administrator and the POA, and an event occurrence is filed. She further explained that the POA, family, or visitors are asked if they took the item when visiting. The RN stated that if the item is still not located, social services takes over from this point. She was unsure if the facility replaces missing items.</p> <p>Interview was conducted on April 17, 2025 at 2:48PM with the Social Services Director (Staff #9), who stated that items brought into the facility should be written on the resident's inventory sheet, as long as the family notifies the staff that they have brought in the items. She also stated that clothing is taken by housekeeping for labeling and is brought back to the resident. The Social Services Director stated that if an item is reported missing by a resident, staff will begin searching for the item, and staff attempt to ask the resident where it was last seen. She stated that staff will ask the resident if they are missing the item or if they suspect it was stolen. If the resident suspects theft, then staff are expected to report this to appropriate agencies. From this point, a five-day investigation is completed. She also stated that a complete investigation is conducted, even if the occurrence is not deemed to be a reportable event.</p> <p>Interview was conducted on April 23, 2025 at 10:42AM with Resident #11, who recalled that he had some clothing go missing around the time he admitted to the facility in December 2024. The resident recalled that laundry had taken some of his clothing off of his shelf to put his name in them, but laundry never returned them. The resident reported that he filed a grievance against the housekeeping department in response to the taken items, and police came to the facility. The resident denied that the items were ever returned or replaced by the facility, and he is unsure what ever came of the situation. The resident reported that his wife brought replacement clothes for him.</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 - Some</p>	<p>Interview was conducted on April 23, 2025 at 10:49AM with a Medical Social Worker (Staff #47), who stated that if a resident reported stolen or missing items, he would attempt to look in the rooms, and if it is not found, he is mandated to report it within forty-eight hours. From there, he gives the filled-out grievance form to the administrator or administrative assistant. When asked what types of items required a reportable to be submitted, the social worker replied that items with monetary value or cash are required to be reported, and it was rare to report other missing items to outside agencies. When asked about Resident #11's missing items in December 2024, the social worker recalled that the resident had reported a few missing rings and some missing clothing, including two special shirts. When asked if staff were able to determine when the items were last seen, the social worker referenced his progress note from December 10, 2024. Upon reviewing this note, he could not determine details on when the items were last seen, but stated that the process for when a resident admits to the facility is for items to be taken for inventory and then to housekeeping for name tags to be placed onto the items. The social worker stated that he believed that one or two of the missing rings had been found, and he could not state what the outcome of the clothing was. The social worker stated that Resident #11 had told him to not worry about the clothing. The social worker explained that the clothing items did not have much monetary value, and the resident said to not worry about it, so he did not pursue these items much. The social worker acknowledged that while these items may not have had much monetary value, he could not say if the resident's clothing had sentimental value or if the resident would have been upset about the lost clothing. He stated that he would have to ask the resident to determine the outcome of the investigation.</p> <p>A follow-up interview was conducted on April 24, 2025 at 08:30AM with the Social Services Director (Staff #9). When asked how the facility determines that staff are not responsible for missing items, the Social Services Director stated that the resident is interviewed with open-ended questions. She stated that if the resident reports that they believed someone stole the items, it is brought to the administrator. She reported that video cameras should be reviewed and staff should be interviewed. She stated that sometimes other residents on the hall will be interviewed to see if they have had similar concerns.</p> <p>-Resident #30 was admitted originally on March 22, 2012 and readmitted on [DATE] with diagnoses that included malignant neoplasm of rectum, quadriplegia c5-c7 and ptsd.</p> <p>Review of the MDS dated [DATE], revealed a BIMS score of 15, which indicated that the resident was cognitively intact.</p> <p>Review of a progress note dated February 13, 2023 at 14:29 indicated that the resident alleged that two Certified Nursing assistants approached him the prior weekend and asked for his money since he could not have it in his possession. The note further revealed that the resident stated it was \$100 that was taken and that a grievance statement was filed and taken to the Director of Nursing (DON).</p> <p>A review of the facility reportable investigation dated February 16, 2023 revealed no resident or staff interviews. There was no interview conducted with the alleged victim or perpetrator either. There were no conclusive remarks regarding the residents' allegations either.</p> <p>-Resident #3 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis and heart failure.</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 - Some</p>	<p>Review of the MDS dated [DATE] revealed a BIMS score of 14, which indicated that the resident was cognitively intact.</p> <p>Review of the progress notes revealed that on November 28, 2023, Resident #3's family member reported to staff that Resident #3's jewelry was missing. At this time, Resident #3 was in the hospital.</p> <p>Further review of the progress notes revealed that on December 4, 2023, social services received a grievance form from Resident #3's family member, which mentioned a bunch of money. The social services note revealed that the Social Worker (Staff #91) spoke to Resident #3's family member. The family denied knowing how much money was missing, and staff informed the family that Resident #3 had recently put money into the bank service at the facility. The family also discussed and provided details on the missing jewelry, which included two gold necklaces (one with a crucifix), three gold rings, and a gold chain. The note indicated that the writer had submitted a report about this situation.</p> <p>Further review of the progress notes revealed that on December 5, 2023, the social worker (Staff #91) attempted to call Resident #3's family member but was unable to reach him.</p> <p>A progress note dated December 6, 2023 revealed that a social worker (Staff #91) spoke with Resident #3's family member again. This note indicated that staff had investigated the report of missing jewelry, and staff had discovered that Resident #3 wore his jewelry to the hospital. The note did not specify how staff were able to discover this information.</p> <p>All grievances and investigations for Resident #3 in 2023 were requested to the facility on April 16, 2025 at 9:30AM. Among the documents provided, there was no evidence of any grievances or investigations for November or December 2023.</p> <p>Grievances and investigations for Resident #3 for November and December 2023 were again requested to the facility on April 16, 2025 at 2:24PM. The facility's administrator responded with a statement that said that the facility was unable to find any records that matched this request. An additional request was made on April 21, 2025 at 10:09AM for investigations relating to Resident #3 for November-December 2023, and the facility was again unable to provide these records.</p> <p>Interview was conducted on April 23, 2025 at 10:49AM with a Medical Social Worker (Staff #47), who stated that he could not recall how long grievances are logged or maintained for. He stated that he would make sure to keep grievances that are still relevant.</p> <p>Interview was conducted on April 24, 2025 at 9:19AM with a Medical Social Worker (Staff #91), who confirmed that she was familiar with Resident #3. The social worker reviewed her progress notes in Resident #3's chart. She confirmed that she had been in communication with Resident #3's family about missing jewelry and money. Upon review of her notes, the social worker recalled that she was able to determine that Resident #3 wore his jewelry to the hospital. The social worker stated that the resident normally did not take off his rings. When asked how the social worker was able to make the determination that the resident wore his jewelry to the hospital, the social worker attempted to locate the grievance mentioned in her progress notes. After a brief search in her cabinets, the social worker stated that she sometimes keeps a copy of grievances and she would search for the grievance. The social worker could not recall how long grievances were kept for.</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 - Some</p>	<p>Interview was conducted on April 24, 2025 at 11:15AM with the Administrator (Staff #97), who confirmed that he was the abuse officer. The Administrator also explained that once an allegation of abuse or misappropriation is received, staff report it to him. From this point, the administrator determines who conducts the investigation based on what the allegation was. The administrator described that during the investigation, the investigator should speak to the people involved. He also stated that if the allegation involved staff-to-resident abuse, the staff suspected would be placed on administrative leave during the investigation. He elaborated that any witnesses would be interviewed, and any staff who were sent home on administrative leave would also be interviewed. The administrator also stated that the investigator would also ask other residents on the hall about the staff in question, and would ask if the residents felt safe or if they had been harmed. When asked if the facility maintains record of any investigations conducted, the administrator stated that the facility kept the past one or two years of investigations in file cabinets in the office, and would keep records from 2022 to 2023 in a storage room near the office. He explained that medical records staff would evaluate how long the records needed to be kept and if any could be disposed of, though the administrator was unaware of the length of time the records had to be kept. The administrator stated that to his knowledge, the investigations provided to the surveyor team were the completed investigations. He also stated that the risks of not conducting a complete investigation into allegations would be that the allegation may be true and it would not be able to be verified if not fully investigated, which could result in residents being injured or stolen from.</p> <p>-Resident #54 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, Hemiplegia, and hemiparesis following cerebral infarction affecting the left non-dominant side.</p> <p>Review of the BIMS assessment dated [DATE], reveals a BIMS score of 15, which indicated that the resident was cognitively intact.</p> <p>Review of the resident's progress notes dated May 08, 2024, revealed that at approximately 11:53 AM, the assigned nurse informed TW that she was told by CNA that the veteran was bleeding from the bottom. Noted a moderate amount of blood on the floor. Noted shearing approximately 3cm x 3cm shearing with small bleeding noted. Blanchable redness on the back. The veteran stated he had redness to his buttocks, but it was not open. Vet stated injury happened when she was pulling the sling from under me and pulling the shorts off. CNA said the veteran told him he had something on his bottom, she saw blood where the veteran was sitting, and notified the nurse.</p> <p>Further review of the resident's progress notes dated May 08, 2024, at 3:33 PM, A telephone order was received from the resident's primary physician to clean left buttock skin shearing with Normal Saline, pat dry, apply bacitracin, and a dry dressing three times a day.</p> <p>Review of the facility investigation dated April 25, 2024, revealed that there were no resident interviews conducted, nor were skin assessments attached. Further review revealed that there was no thorough investigation conducted.</p> <p>Grievances and investigations for Resident #54 for May 2024 were requested by the facility on April 16, 2025, at 2:24PM. The facility's administrator responded with a statement that said the facility was unable to find any records that matched this request.</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 - Some</p>	<p>An interview was conducted on April 22, 2025, at 10:00 AM, with the resident #54, who reported that the CNA was a bit rough when pulling the Hoyer sling cloth out from his bottom, and it caused an open wound that was bleeding significantly. The resident clarified that the staff did not cause the injury intentionally. He mentioned that incidents can happen, and he was unaware that informing the nurse would result in someone getting in trouble. He also stated that he has a good relationship with the staff.</p> <p>An interview was conducted on April 22, 2025, at 2:51 PM, with the Certified Nursing Assistant (staff#104), who stated that when she provided a shower to the resident that day, she remembered that there was another Certified Nursing Assistant who was helping her. She stated that it wasn't a Hoyer sling that the resident was seated on; the resident was wearing shorts, and she noticed that his shorts were a little loose on him when she pulled his shorts.</p> <p>An interview was conducted on April 22, 2025, at 1:45 PM, with the interim DON (staff#102), who stated that whoever is in charge of the resident, whether the LPN or RN, should report the incident to the abuse coordinator. An investigation will be conducted, and the staff will be separated from the resident. The incident will be reported to a third-party agency, including the police, POA, and the ombudsman. Staff are typically suspended if there is staff-to-resident abuse, and HR will be involved. Abuse training is provided to the staff annually and as needed. She stated that she wasn't the DON when the staff-to-resident incident occurred.</p> <p>-Resident #129 was admitted [DATE] with diagnoses that included end stage renal disease, major depressive disorder, PTSD, polyosteoarthritis, hyperlipidemia, hypertension and atherosclerotic heart disease of native coronary arteries.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], revealed the resident was assessed for mental status due to the inability to complete the Brief Interview for Mental Status assessment.</p> <p>Review of the resident ' s progress notes dated April 24, 2024 at 12:28 p.m., revealed the transportation company ' s representative called the facility and reported that during transportation to a medical appointment the resident was involved in a vehicular accident. The note further states that the resident was dropped off at dialysis and that the nurse notified the resident ' s Power of Attorney (POA) of the accident.</p> <p>Another progress note dated April 24, 2024 at 23:04 p.m., revealed that the resident was brought back to the facility by POA with no concerns and that neurological checks were started.</p> <p>Review of the facility investigation dated April 26, 2024, revealed that there were no staff or resident interviews conducted. Further review revealed that there was no evidence of skin assessments being done. Further review revealed that there was no evidence of a conclusive ending to the investigation.</p> <p>-Resident #146 was admitted on [DATE] with diagnoses that included glaucoma, PVD, pneumothorax, obstructive and reflux uropathy, pressure ulcer, insomnia, constipation and chronic pain.</p> <p>Review of the MDS dated [DATE], revealed a BIMS summary score of 15 which indicated that the resident was cognitively intact.</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 - Some</p>	<p>Review of the resident ' s progress notes dated August 16, 2022 11:03 a.m., revealed the transportation company ' s staff member reported that the resident had hit his head while getting into the van. The progress note further revealed that an assessment was performed and the resident denied any type of pain.</p> <p>Review of the facility investigation dated August 22, 2022, revealed that there were no resident interviews conducted. Further review revealed that there was no evidence of a conclusive ending to the investigation.</p> <p>-Resident #14 was admitted on [DATE] with diagnoses that included macular degeneration, diabetes, speech disturbances, muscle spasm, xerosis cutis, neoplasm of right choroid, presence of intraocular lens, periostitis of right orbit, astigmatism and presbyopia.</p> <p>Review of the MDS dated [DATE], revealed a BIMS summary score of 15 which indicated that the resident was cognitively intact.</p> <p>Review of the resident ' s progress notes dated July 7, 2022 at 11:24 a.m., revealed the transportation company ' s staff member reported that the resident lost control while wheeling himself down a sidewalk and ended up tipping his wheelchair over and causing injury. The progress note further revealed that the resident was transported to the hospital via ambulance.</p> <p>Further review of the resident ' s progress notes dated July 8, 2022 at 14:18 p.m., revealed the resident was transported back to the facility and measurements regarding the resident ' s injury were notated.</p> <p>Review of the facility investigation dated July 14, 2022, revealed that there were no resident interviews conducted nor were skin assessments attached. Further review revealed that there was no evidence of a conclusive ending to the investigation.</p> <p>-Resident #98 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included permanent atrial fibrillation, pressure ulcer, hematuria, cellulitis, sepsis.</p> <p>Review of the MDS dated [DATE], revealed a BIMS summary score of 14 indicating minimal cognitive impairment.</p> <p>Review of the resident ' s progress notes dated July 7, 2022, revealed that the transportation company ' s representative called to report an incident that occurred on July 6, 2022 about the resident hitting his head and a skin tear to his right arm.</p> <p>Further review of the resident ' s progress notes dated July 7, 2022 at 14:38 p.m., revealed the resident relayed information regarding the incident that occurred the day prior to nurses at the nursing station. The note revealed a bump to the resident's head and the skin tear to the right arm.</p> <p>Review of the facility investigation dated July 14, 2022, revealed that there were no resident interviews conducted nor were skin assessments attached. Further review revealed that there was no evidence of a conclusive ending to the investigation.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Arizona State Veteran Home-Phx		STREET ADDRESS, CITY, STATE, ZIP CODE 4141 North S Herrera Way Phoenix, AZ 85012	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on April 24, 2025 at 10:11 a.m., with a Medical Social Worker (Staff #91), who stated that the process of a reportable incident is for the administrator to overview it and deem it appropriate to report. Staff #91 then stated that the investigation will be given to the appropriate department (i.e. nursing, social services or administration). The medical social worker then stated that the investigation includes victim and perpetrator interviews in addition to other resident and staff interviews on a sampled scale.</p> <p>Interview was conducted on April 24, 2025 at 11:15AM with the Administrator (Staff #97), who confirmed that he was the abuse officer. The Administrator also explained that once an allegation of abuse or misappropriation is received, staff report it to him. From this point, the administrator determines who conducts the investigation based on what the allegation was. The administrator described that during the investigation, the investigator should speak to the people involved. He also stated that if the allegation involved staff-to-resident abuse, the staff suspected would be placed on administrative leave during the investigation. He elaborated that any witnesses would be interviewed. The administrator also stated that the investigator would also ask other residents on the hall about the staff in question, and would ask if the residents felt safe or if they had been harmed. When asked if the facility maintains record of any investigations conducted, the administrator stated that the facility kept the past one or two years of investigations in file cabinets in the office, and would keep records from 2022 to 2023 in a storage room near the office. He explained that medical records staff would evaluate how long the records needed to be kept and if any could be disposed of, though the administrator was unaware of the length of time the records had to be kept. The administrator stated that to his knowledge, the investigations provided to the surveyor team were the completed investigations. He also stated that the risks of not conducting a complete investigation into allegations would be that the allegation may be true and it would not be able to be verified if not fully investigated, which could result in residents being affected or injured.</p> <p>Review of the facility policy titled, Grievances/Complaints, Filing, dated April 2017, revealed that upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five working days of receiving the grievance and/or complaint. This policy also revealed that the results of all grievances files, investigated and reported will be maintained on[TRUNCATED]</p>		

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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>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** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure resident #49 was free from elopement. The deficient practice could result in further incidents of elopement or physical injury.</p> <p>Findings include:</p> <p>Resident #49 was admitted on [DATE] with diagnosis included Hemiplegia, Vascular dementia, psychotic disturbance, mood disturbance, anxiety, and major depressive order.</p> <p>A wandering assessment done October 01, 2022 revealed that resident is physically able to leave the building on their own and no behaviors exhibited for wandering.</p> <p>A care plan dated October 19, 2022 had focus area for Cognitive loss/Dementia. Goal: Veteran will attend activities are focused on memory. Veteran will work on communicating verbally or non-Verbally regarding his memory. Approach: notify Medical Doctor of any changes in cognition/condition, staff will provide emotional support as needed, Social worker conduct assessments as needed to observe for any changes in cognition.</p> <p>A wandering Risk assessment conducted on October 01, 2022 revealed that the resident was not at elopement risk and did not exhibit any wandering behaviors. It also revealed preventative measure were to have identification band on resident.</p> <p>A progress note dated December 16, 2022, revealed that resident was not found during medication pass; and that, security was called at 10:15AM-10:30AM and alert code pink was called. Vet had left the facility premises and was found by his wife at 70ave and [NAME]. Upon return, wheelchair was placed on manual and he refused to be removed from his wheelchair.</p> <p>A review of event report of elopement dated December 16, 2022, revealed that resident exhibited behaviors of elopement and attempted to leave in past but was unsuccessful. Evaluation notes: event reviewed, wander guard placed, and resident has been evaluated for need for secured unit along with pictures posted in appropriate places in the unit.</p> <p>A progress note dated December 17, 2022, still refused to give up his wheelchair, he denied any pain, was educated of safety reasons and still refused, wander guards placed to prevent episode wandering during the shift and was on continuous monitoring.</p> <p>A facility investigation report dated December 21, 2022, revealed that resident had eloped from the facility and was found by his wife on 70 th ave and [NAME]. The reason why resident elope because he wanted to take care of his sick wife who was just released from hospital. Resident was not elopement</p> <p>(continued on next page)</p>		

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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>risk prior to the incident. After the incident the resident ' s electric wheelchair was placed on Manual mode and wander guard was placed on his chair.</p> <p>Wandering Assessment report dated January 05, 2023 revealed that resident is able to leave the building by their own, wandering alarm is used to daily, resident is not disorientated to place, elopement success in the past. Interventions measures are placed such has activities and door alarm band applied. Preventative measures include clothing labeled with identification and door alarm band applied e.g wander guard.</p> <p>A care plan dated January 24, 2023, had focus area of behavioral symptoms of wandering, pacing or roaming related to the diagnosis of unspecified symptoms and signs cognitive functions and awareness. Goal: The resident will remain safely engaged in activity-focused care, a meaningful intervention, or social interaction without trying to elope from the facility (by the next 90-day review). Approach: assess for potential elopement/unauthorized departure risk. Make rounds/rooms check per facility protocol to minize change of unauthorized leave, use positive language, and provide simple, clear direction to help resident know what is expected.</p> <p>A quarterly admission Minimum Data Set (MDS) assessment dated [DATE], revealed no Brief Interview for Mental Status (BIMS) Assessment score.</p> <p>A quarterly wandering assessment dated [DATE] revealed that resident is able to physically leave the building their own, wandering behaviors not exhibited and not risk of getting to dangerous place. Alarm and wander elopement guards are placed daily, is not disoriented to place, able to make its own</p> <p>decisions, resident has elopement success in the past. Has changes in medication Prozac dosage decreased from 60 milligram (mg) to 40 mg. Resident had CVA and depression, resident not present elopement risk. Preventative measure clothing labels with identification and identification band on resident.</p> <p>Review of the progress note dated September 15, 2023, revealed that resident was not found while doing med pass, he left the facility without a pass and was found by director of rehab on 7 th street and Palm lane in his electric wheelchair. Veteran stated that he was going to Chase Bank. When waiting on Van Veteran kept attempting to leave and was educated and instructed on travel policy and that it could be considered as elopement. When Veteran and Director of Rehab decided to start head back to the facility resident demonstrated impaired safety awareness in his electric wheelchair running into fire hydrants, getting stuck on a curb, crossing the cross walk at unsafe times and was following instructions for safety. Veteran was returned to facility with Director of Rehab via Van.</p> <p>A wandering assessment dated [DATE] revealed that resident left the building without pass, the resident is physically able to leave the building on their own, has electric wheelchair/scooter, wandering behavior is exhibited, preventative measures are door alarm band applied-e.g. wander guard</p> <p>and identification band on resident. Interventions measures taken were physician/nurse practitioner/ Physician assistant. Resident had Depression and Post-Traumatic Stress Disorder.</p> <p>(continued on next page)</p>		

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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 care plan dated September 15, 2023 had focus area movement behavior of wandering. Interventions included apply wander guard to vet ' s electric wheelchair to notify staff if veteran leaves and take note of the most likely times of day for wandering. Plan the activities of the patient during that time.</p> <p>A facility investigation report dated September 18, 2023, which revealed that code pink was called at 11:30PM when resident was not found in the building and the writer went in the car to find the resident and he was found at 12:08pm. Resident was asses after returned to the facility. Interventions were put in place such as guard place on resident, wife was contacted for permission, and asked if this was appropriate setting for the resident stay at the facility.</p> <p>An interview was conducted on April 18, 2025 at 2:40PM with Certified Nurse Assistant (CNA/staff #84), who stated she considers elopement when resident tries to leave the facility without notifying anyone. She stated that the facility process for elopement is to check the resident all over the facility and call security, check the facility as well. She stated some preventative measures for resident who are risk of elopement would be to have bracelet on the resident which triggers the alarm if they try to leave the facility. She stated some of the risk of resident eloping would be the resident getting hurt, car might hit them, and</p> <p>they will not know where they are going.</p> <p>An interview was conducted on April 18, 2025 at 2:46PM with Certified Nurse Assistant (CNA/staff #101), who stated that elopement is when resident leaves facility, runs away, or resident does not know where they at. He stated that facility process for elopement is to call the police and notify the family.</p> <p>CNA stated some interventions for resident who are at elopement risk that have wander guards on them and have one-on-one staff. He stated that if resident tries to leave that the alarms go off and they have pagers to know if someone has eloped.</p> <p>An interview was conducted on April 18, 2025 at 2:52PM with Licensed Practical Nurse (LPN/staff #80), who stated elopement is anybody goes of the ground or parking lot area of the facility. She stated that independent traveler is able to go out of the facility by themselves, but only if they are evaluated by the</p> <p>doctor and has doctors note. The independent travel is care planned. She stated that anyone who is not independent traveler would be signed off by someone. She stated that if someone leaves the premiseses and can ' t find them, they would call code pink which sets off everyone to look for the resident, nursing</p> <p>supervisor notified, outside agency are notified, the police is called, and continue to search. LPN mentioned that resident #49 is not independent traveler and has wander guard placed. She stated that he has elopement history because he ran and left the premises of the building without anyone signing</p> <p>(continued on next page)</p>		

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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>him off. She stated some risk pose to him leaving the facility without someone signing him off would be emotional change, risk of fall, confusion, misdirection because he is unable to communicate with public and he is evasive. She stated that his electric chair would go low on battery and he could injure himself.</p> <p>An interview was conducted on April 21, 2025 at 8:45AM with Licensed Practical Nurse (LPN/staff #100), who stated that resident #49 has eloped from the facility in his electric wheelchair because he wanted to go home. She stated that security guard alerted them when he left the premises. He was found on the 7 th street which would be considered as elopement. She stated that the wife comes quite often to see him.</p> <p>An interview was conducted on April 21, 2025 at 8:58AM with the Social Service Director (staff #103), who stated that elopement is when someone leaves the facility without signing out with the responsible party and when residents do not have approval of independent traveler. She stated that who ever is independent travel they are approved by the doctor. The security guard had list of independent traveler list and they need to sign out when they leave the building. Anyone who is independent traveler they are care planned for it. Social Service Director stated that if resident is elopement risk they are placed on wander guards, if they are try to leave the building it will beep and staff member will be aware to search the resident. Staff stated that she is familiar with resident #49 and confirmed that he eloped multiple times. She stated that he eloped in December 2022, and September 2023 where rehab director found him. She stated he has not been approved for independent traveling. She stated some risks for him eloping would be his electric wheelchair can breakdown, could have fall, not figuring out where he is, not able to communicate due to dysphagia.</p> <p>An interview was conducted on April 21, 2024 at 2:56 PM with interim Director of nursing (DON/ Staff #102), who stated that elopement is defined as when someone left the facility without notifying anybody. She stated that they do assessment for resident to see if resident is elopement risk. If they are elopement risk they put wander guard. She stated that if someone elopes they would start the elopement process. She stated that she does not know exactly what the elopement process is. Then later she looked up the policy stated that the elopement process is to identify where the resident is at, look at the camera, to search the facility, and look in the front of the park. If not found call the police and notify administrator. She stated some risk of resident eloping would be getting injured, something can happen to them, and they can get lost in the park and fall.</p> <p>An interview was conducted on May 1, 2025 at 2:52PM with Licensed Practical Nurse (LPN/staff #60), who stated that elopement is escape, resident leaving against medical advice, want to go out, and want to go somewhere; and that, an independent traveler are able to go out and sign out themselves and who are not independent travelers can still go out, but someone has go out with them such as family member or staff member. She stated that it should be care planned if they can or not go out by themselves and all the resident are assessed upon admission by nursing supervisor if they are at risk of elopement by asking</p> <p>(continued on next page)</p>		

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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>series of question like -- do they want to go home?, if they are ok here?, or they want to go somewhere else?. They also ask family members if they have any history of elopement or wandering if the resident are not cognitively intact. She stated that if resident is at risk for eloping then they place them on wander guard. If resident tries to leave the unit the alarm will go off or if they try to leave. She stated that the staff members make sure they check up on these patients and know where they at. She stated that resident #49 is on wander guards and wife comes often and take him off home for one day pass. LPN also stated</p> <p>that the resident has eloped and has history of wandering. They make sure he is safe by checking often. She stated resident has eloped from the facility, but does not remember when he was last eloped.</p> <p>Review of the policy titled Emergency Procedure-Missing Resident (revised August 2018) revealed that residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety.</p>		