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	05/15/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50166 Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that the abuse policy was adhered to following an incident involving an injury of unknown origin for one of three sampled residents (#3). The deficient practice could result in abuse policies not being followed, which could result in residents being harmed. Findings include: Resident #3 was admitted on [DATE] with diagnoses that included type 2 diabetes, fecal impaction, hypotension, streptococcus group B, post-traumatic stress disorder, depression, adjustment disorder, pneumonia, hyperlipidemia, and hypoglycemia. An Annual Minimum Data Set (MDS) assessment initiated on May 8, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the facility investigation for an injury of unknown origin dated May 6, 2025 revealed that staff made a report to AZDHS at 6:25 a.m. on May 7, 2025 following Resident #3 complaining of left hand pinky finger pain. The investigation revealed that the pinky finger was red, swollen, and painful, and an x-ray was completed to reveal a nondisplaced fracture. The investigation further revealed that an interview was conducted with the resident who was unaware of how the injury occurred, and the resident did not believe he had a recent fall. The facility investigation was unsubstantiated due to the x-ray report showing mild osteopenia, mild osteoarthritis, and bony mineralization being mildly decreased. However, the facility investigation revealed no evidence of further interviews conducted with staff, family, visitors, other departments, or other residents. A progress note dated May 7, 2025 at 6:56 a.m. revealed that staff identified and reported an allegation of neglect, abuse, misappropriation of property, and exploitation to the Arizona Department of Health Services (AZDHS), Adult Protective Services (APS), Ombudsman, police department, Assistant Director of Nursing (ADON/Staff#63), and the Administrator (Admin/Staff#101). An interview was conducted on May 15, 2025 at 12:07 p.m. with a Registered Nurse, (RN/Staff#42) who stated that she did not know how the resident sustained the injury to his finger, but if she had discovered it, her process would be to document and report the event before beginning to interview and take statements from the people involved as per the facility policy. The RN stated that she would always document who she talked to and she would call the doctor, responsible party, charge nurse, administrator, ombudsman, and police, if applicable. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	05/15/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted on May 15, 2025 at 12:15 p.m. with a Certified Nursing Assistant, (CNA/Staff#70) who stated that if she identified an injury of unknown origin, she would report it right away to the nurse and get a documented interview with the resident to see what happened as per the facility policy. An interview was conducted on May 15, 2025 at 12:45 p.m. with the Interim Director of Nursing, (DON/Staff#30) who stated that if an injury of unknown origin were reported to the facility, they would need to interview residents, visitors, and all staff working on the floor according to the facility policy for abuse investigations. The DON stated that the incident report would contain all of the interviews in the form of handwritten statements that were signed by the person interviewed. The DON stated that the risk of not thoroughly investigating injuries of unknown origin would be a negative outcome to the resident. An interview was conducted on May 15, 2025 at 12:55 p.m. with the ADON, Staff #63, who stated that if an injury of unknown origin were reported to the facility, they would complete an investigation which would involve interviews with staff, residents, other departments, hospital staff (if applicable), or visitors. The ADON stated that the interviews for the investigation would need to be handwritten statements with the date, time, and signature of the person who was interviewed. The ADON further stated that they needed to interview as many people as it would take to get to the bottom of an allegation starting with the resident and all staff on the unit for all of the different shifts as per the facility policy. The ADON stated that the risk of not thoroughly investigating injuries of unknown origin would be potential continued abuse or residents doing something to jeopardize their safety. An interview was conducted on May 15, 2025 at 1:03 p.m. with the Administrator, Staff #101, who stated that if an injury of unknown origin were reported to the facility, they would need to complete an investigation which would involve interviews with the resident and staff members on the floor, and interviews would be documented on the interview or witness forms to become a part of the investigation documentation. The Administrator further stated that the investigation of the injury for Resident #3 was different because she, was not led down the path to interview. The administrator stated they were required to interview during an investigation, and that the risk of not thoroughly investigating could be that they would not fully know what happened to a resident, and residents could be exposed to a risk from a staff member or outside person. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, revealed that all allegations of resident abuse, including injury of unknown origin, were reported to local, state, and federal agencies and thoroughly investigated by facility management. This policy also indicated that the individual conducting the investigation as a minimum should interview: the person reporting the incident; any witnesses to the incident; the resident or representative; staff members who had contact with the resident during the period of the alleged incident; the resident's roommate, family members, and visitors. The policy indicated that the investigation should be documented completely and thoroughly, and any witness statements should be obtained in writing, signed, and dated.

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	05/15/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50166 Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that an incident involving a reported injury of unknown origin was thoroughly investigated for one of three sampled residents (#3). The deficient practice could result in injuries of unknown origin occurring without being appropriately investigated or identified in order to implement measures to protect residents. Findings include: Resident #3 was admitted on [DATE] with diagnoses that included type 2 diabetes, fecal impaction, hypotension, streptococcus group B, post-traumatic stress disorder, depression, adjustment disorder, pneumonia, hyperlipidemia, and hypoglycemia. An Annual Minimum Data Set (MDS) assessment initiated on May 8, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the facility investigation for an injury of unknown origin dated May 6, 2025 revealed that staff made a report to AZDHS at 6:25 a.m. on May 7, 2025 following Resident #3 complaining of left hand pinky finger pain. The investigation revealed that the pinky finger was red, swollen, and painful, and an x-ray was completed to reveal a nondisplaced fracture. The investigation further revealed that an interview was conducted with the resident who was unaware of how the injury occurred, and the resident did not believe he had a recent fall. The facility investigation was unsubstantiated due to the x-ray report showing mild osteopenia, mild osteoarthritis, and bony mineralization being mildly decreased. The facility investigation revealed no evidence of further interviews conducted with staff, family, visitors, other departments, or other residents. A progress note dated May 7, 2025 at 6:56 a.m. revealed that staff identified and reported an allegation of neglect, abuse, misappropriation of property, and exploitation to the Arizona Department of Health Services (AZDHS), Adult Protective Services (APS), Ombudsman, police department, Assistant Director of Nursing (ADON/Staff#63), and the Administrator (Admin/Staff#101). An interview was conducted on May 15, 2025 at 11:55 a.m. with Resident #3 who stated that he did not know where or how the injury to his pinky occurred. The resident further stated that he noticed it was hurting when he woke up and an x-ray revealed it was broken. An interview was conducted on May 15, 2025 at 12:07 p.m. with a Registered Nurse, (RN/Staff#42) who stated that she did not know how the resident sustained the injury to his finger, but if she had discovered it, her process would be to document and report the event before beginning to interview and take statements from the people involved. The RN stated that she would always document who she talked to and she would call the doctor, responsible party, charge nurse, administrator, ombudsman, and police, if applicable. An interview was conducted on May 15, 2025 at 12:15 p.m. with a Certified Nursing Assistant, (CNA/Staff#70) who stated that if she identified an injury of unknown origin, she would report it right away to the nurse and get a documented interview with the resident to see what happened. (continued on next page)

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	05/15/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted on May 15, 2025 at 12:45 p.m. with the Interim Director of Nursing, (DON/Staff#30) who stated that if an injury of unknown origin were reported to the facility, they would need to interview residents, visitors, and all staff working on the floor. The DON stated that the incident report would contain all of the interviews in the form of handwritten statements that were signed by the person interviewed. The DON stated that the risk of not thoroughly investigating injuries of unknown origin would be a negative outcome to the resident. An interview was conducted on May 15, 2025 at 12:55 p.m. with the ADON, Staff #63, who stated that if an injury of unknown origin were reported to the facility, they would complete an investigation which would involve interviews with staff, residents, other departments, hospital staff (if applicable), or visitors. The ADON stated that the interviews for the investigation would need to be handwritten statements with the date, time, and signature of the person who was interviewed. The ADON further stated that they needed to interview as many people as it would take to get to the bottom of an allegation starting with the resident and all staff on the unit for all of the different shifts. The ADON stated that the risk of not thoroughly investigating injuries of unknown origin would be potential continued abuse or residents doing something to jeopardize their safety. An interview was conducted on May 15, 2025 at 1:03 p.m. with the Administrator, Staff #101, who stated that if an injury of unknown origin were reported to the facility, they would need to complete an investigation which would involve interviews with the resident and staff members on the floor, and interviews would be documented on the interview or witness forms to become a part of the investigation documentation. The Administrator further stated that the investigation of the injury for Resident #3 was different because she, was not led down the path to interview, and the resident denied having a problem with staff, which meant there was no reason to interview. The administrator stated they were required to interview during an investigation, and that the risk of not thoroughly investigating could be that they would not fully know what happened to a resident, and residents could be exposed to a risk from a staff member or outside person. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, revealed that all allegations of resident abuse, including injury of unknown origin, were reported to local, state, and federal agencies and thoroughly investigated by facility management. This policy also indicated that the individual conducting the investigation as a minimum should interview: the person reporting the incident; any witnesses to the incident; the resident or representative; staff members who had contact with the resident during the period of the alleged incident; the resident's roommate, family members, and visitors. The policy indicated that the investigation should be documented completely and thoroughly, and any witness statements should be obtained in writing, signed, and dated.