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	12/09/2025

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. (continued on next page)

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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review, review of facility documentation, and review of facility policy and procedure, the facility failed to protect the rights of one (#67) of five sampled residents to be free from abuse by another resident (#61). The deficient practice could result in further abuse of residents and appropriate action not taken.Findings include:-Resident #67 was admitted to the facility on [DATE], with diagnoses of senile degeneration of the brain, dementia with other behavioral disturbance and severe anxiety, unspecified mood affective disorder, adjustment disorder, and insomnia.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident had memory problem both for short-term and long-term memory. Additionally, the assessment indicated that the resident had some difficulty in new situations pertaining to cognitive skills for daily decision making. Further review of the MDS revealed that resident #67 had exhibited no verbal or physical behavioral symptoms directed towards others during the assessment period. A cognition/dementia care plan initiated on April 7, 2025, revealed that resident #67 had a history of disturbance in thought process and was unable to follow both verbal and visual cues. Interventions included alerting the medical provider regarding changes in cognition with the goal of maintaining his functional independence as much as possible. An RN (Registered Nurse) progress note dated November 23, 2025 documented that a Certified Nursing Assistant (CNA) reported that a resident approached resident #67 from behind, placed his hands on resident #67's head, and moved resident #67's head side to side. Per the note resident #67 had a habit of counting out loud and the counting had aggravated the other resident. Residents were separated by the CNA and no injuries were noted to either resident. An RN note dated November 24, 2025, documented an Alert Charting and indicated Vet accosted. The note revealed that resident #67 was observed in his room, dining hall and common areas without issue. Per the note the resident was not approached by other residents and appeared to be in no distress. A Social Services progress note dated November 25, 2025 documented that resident 67's son was informed that the resident would be moved to a room upstairs for his safety, by the end of the week. Review of the Resident Census documented a room change in which resident #67 was moved from unit C1 to unit C2 on November 26, 2025.A Nursing progress note dated November 26, 2025 stated that the resident was moved to room C261.-Resident #61 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of Alzheimer's disease, dementia with unspecified severity and other behavioral disturbance, psychotic disorder with delusions due to known physiological condition, psychotic disorder with delusions due to known physiological condition, adjustment disorder with mixed disturbance of emotions and conduct, and insomnia.A review of the quarterly Minimum Data Set (MDS) assessment for resident #61 dated November 13, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. A late entry NP (Nurse Practitioner) note regarding a psychiatric reevaluation dated November 15, 2025, documented that resident #61 was assessed to have displayed relative stability on current treatment plan. Per the assessment the resident's functional impairment and behaviors were consistent with dementia progression. The reevaluation included medication review. According to the reevaluation no medication changes were recommended and the resident progress will be monitored and the indication and efficacy of current treatment regiment will be reevaluated. Additionally, the reevaluation included a plan for resident to be encouraged to socialize with other residents for improved quality of life. A behavioral care plan revised November 17, revealed that resident #61 had a history of socially inappropriate and disruptive behavioral symptoms toward other residents and required continuous supervision. Interventions included assessing whether the behavior endangers resident #61 and other residents. When behaviors occur provide redirection to divert resident from the peer that may be causing the frustration or behavior. The goal of the focus was for resident #61 not to harm self or others. An RN (Registered Nurse) progress note dated November 23, 2025 documented that a Certified Nursing Assistant (CNA) reported that a resident was sitting in his wheelchair in a common area of the facility when resident #61 approached the resident from behind, placed his hands on either side of the other resident's head and moved it from side to side. The progress note indicated that the other resident had a habit of counting out loud and the counting had aggravated resident #61. Residents were separated by the CNA and no injuries were noted to either resident.A Nursing progress note dated November 25, 2025 documented that resident #61 was returning from being weighed by a CNA when he overheard another resident counting out loud. Resident #61 stated I am tired of listening to him count all of the time. He's a