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	05/05/2026

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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, policy and procedures, the facility failed to ensure adequate supervision to prevent elopement for one resident (#1) out of 3 sampled residents. The deficient practice could result in avoidable accidents.Findings include:Resident # 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, hypertensive heart disease, and post-traumatic stress disorder. Records revealed a prior history of elopement as evidenced by a facility investigation report dated December 21, 2022 which revealed that Resident # 1 had eloped from the facility on December 16, 2022. The investigation further revealed that Resident # 1 was found not to be in his room during medication pass, and was later located approximately 11 miles from facility heading to his home to be with his wife who was sick. Review of the care plan revealed no evidence of a problem/goal related to the elopement that occurred on December 16, 2022.A physician order dated June 4, 2023 revealed that staff were to document if the resident exhibited any wandering behaviors or behavior of leaving the facility. Further review of the order revealed that it was discontinued on February 18, 2026. A behavioral symptoms care plan initiated on January 9, 2024 revealed that Resident #1 demonstrated unsafe travel outside the facility without responsible party or proper authorization. Interventions included to assess, record, report to Medical Doctor risk factors for potential elopement, if resident is seen wandering in potentially unsafe area of situation, redirect to safer area, leave safe and reassess. An annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the wander-guard was utilized daily. However, the was no evidence in the care plan that the wander-guard had been placed, or interventions regarding the wander-guard.A physician's order dated December 9, 2025 revealed that the facility may place wander-guard on Resident #1.A progress note dated February 14, 2026 revealed that while the resident's spouse was picking up the resident for a home visit and had requested that the wander-guard be removed permanently. The note relayed that the Nurse Practitioner determined that the resident was safe to have the wander-guard removed. Further review of the resident's care plan related to behavioral symptoms, revealed no evidence that the care plan was updated that the wander-guard had been removed on February 14, 2026.Further review of the physician's order for the wander-gaurd, revealed that the wander-guard was discontinued on February 18, 2026.A progress note dated March 5, 2026 revealed that at about 1:14 p.m. the receptionist notified staff that Resident # 1 was by the park entrance across the parking lot. The progress note documented noted that the receptionist had eyes on the Resident the entire time. The note revealed that Resident # 1 was sitting by the entrance talking with other residents who congregate there, and that the resident was redirected back into the facility.A progress note dated March 8, 2026 revealed that the spouse was visiting Resident #1 and requested that her husband have an independent travel pass to the park entrance, to allow the resident to interact with peers.A Quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS assessment revealed that Resident #1 could operate a motorized wheelchair independently 50 and 150 feet with (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two turns, and also revealed that elopement alarms were not used. A progress note dated March 12, 2026 revealed that the physician was in to see Resident # 1 and informed the resident that the travel pass was not approved but could be revaluated in one month. The progress note also revealed that the physician approved visits to the park with spouse or accompanied by staff, and that Recreation Therapy was notified to schedule park walks. Review of the progress notes revealed that Resident #1 went on 6 walks with recreational therapy between March 13, 2026 through April 6, 2025.A behavioral symptoms care plan long-term goal edited on March 13, 2026, revealed that the resident will remain safe within facility unless accompanied by staff, other authorized persons through review date of June 25, 2026. The care plan revealed no evidence that the wander-guard had been removed on February 14, 2026.A progress note dated April 18, 2026 revealed that a Nurse Practitioner (NP) spoke with the Resident's wife regarding the independent pass for the resident to go to the park entrance and no further. The note revealed that the NP and the resident's spouse discussed with the resident that he could go to the park entrance only and not travel further or the independent pass would be taken away. The progress note documented that the resident acknowledged understanding and new order was received for independent travel. Despite the change in orders, there was no evidence that the care plan was updated to reflect the new orders.An Observation Detail List report dated April 18, 2026, revealed that the resident had been approved for an independent travel pass, and was okay to go across the park with peers.A progress note dated May 1, 2026 at 11:54 AM, revealed that at approximately 9:45 a.m. during the morning Interdisciplinary (IDT) Meeting, a code pink was announced on the speaker regarding Resident # 1. The progress note revealed that the writer and another nurse got in their cars to search for Resident # 1, and that calls were made to the resident's and spouse's phones. The progress note relayed that the resident's spouse called the facility back telling the facility that the resident was at their home approximately 24 miles from the facility. Further review of the clinical record revealed no evidence that the resident had been accompanied to the park by staff or other authorized persons, or supervised per the behavioral symptoms care plan, edited on March 13, 2026.A progress note dated May 1, 2026, at 11:57 a.m., revealed that a Registered Nurse (RN) left the facility at approximately 10:20 a.m. to drive around and search for the resident.A progress note dated May 1, 2026 at 12:33 p.m., revealed that a code pink had been initiated, and a LPN and Infection Control Nurse, immediately left the facility in search of the resident, attempting to contact him on his cell phone, as well as his spouse. The note indicated that the surrounding area and nearby business were checked, but the resident was not found. The note relayed that when the LPN and Infection Control Nurse returned to the facility, the resident's spouse contacted the facility and reported she believed that the resident was at her home, but had not visually confirmed his presence. The note included that the spouse later reported that she confirmed the resident was with her, and he refused to return to the facility.A Resident Tracking form dated May 1, 2025 revealed that Resident # 1 was signed out of the building at 8:10 a.m. with the destination listed as the portico, the seating area immediately outside the front doors of the facility. The resident tracking form also revealed the return time as 1:04 p.m. with the comment Code Pink Cancelled. A progress note dated May 1, 2026 at 1:15 p.m. revealed the resident was returned to the facility, by his spouse, in stable condition. The progress note documented that the resident declined assessment and that the doctor was notified. The note documented that a wander-guard order was initiated was applied to the back of the resident's wheelchair. An Event Report, dated May 1, 2026, revealed that the resident left the facility unattended at approximately 8:15 a.m., and was found at his home at 11:01 a.m. The report indicated that the resident had exhibited elopement behaviors in the past, and that the wander-guard was removed on February 14, 2026, per the resident's preference and provider order, but the resident had not exhibited wandering behaviors since. The report indicated that a wander-guard was immediately applied, and the resident may not leave the premises without escort, including park entrance.A Facility Reported Incident (FRI) dated May 5, 2026, revealed that Resident #1 was reported missing from the facility. The report indicated that staff attempted to locate the resident in the facility and (continued on next page)

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The statement did not indicate if the Social Worker Supervisor tried to stop the resident and help the resident to get to a safe place per the care plan, or notified anyone about the resident when he arrived at the facility. The care plan focus related to behavioral symptoms, was edited on May 1, 2026 with updated interventions that included applying a wander-guard to reduce risk of elopement, and to check device for proper functioning.An interview was conducted with the spouse of Resident # 1 on May 5, 2026 at 10:48 a.m., who stated that the facility had notified her sometime between 10:30 a.m. and 11:00 a.m. that Resident # 1 was missing. The spouse stated that she got in her car to drive towards the facility, she realized she could track his phone, and that she was able to track his phone to their house about 24 miles from the facility. The resident's spouse also stated that when she arrived at her home the resident was there waiting for her. The spouse further stated that Resident #1 may have mixed up the days of the week, that she usually comes on saturday, and the Resident thought May 1, 2026 was a saturday and not a friday, so he got worried about her and went home. The spouse stated at first Resident # 1 did not want to go back to the facility but she was able to convince him and they drove back. The spouse stated the resident did not appear injured and was proud of himself for being able to travel home. The spouse stated that a couple weeks ago they had pushed for the wander-guard to be removed and for an independent pass to the park entrance to see friends.An interview was conducted on May 5, 2025 at 12:09 p.m. with the Recreational Therapist (Staff #49), who stated that when residents want to get an independent pass the Recreational Therapy team will work with residents 1:1 taking them for walks through the park. Once the IDT team and doctor feel confident that the resident will be safe for an independent pass, they get a flag to place on their wheelchairs which alert staff driving in the neighborhood if they see a resident with a red flag, that they have an independent pass. The Recreational Therapist stated that they worked with Resident # 1 and watched how the resident maneuvered the wheelchair through the park. The Recreational Therapist also stated that the resident did great with his wheelchair, and that the resident only got hung up off the sidewalk once but was able to maneuver back onto the sidewalk. The Recreational Therapist further stated that with each walk he would stay back and let the resident be more independent, and that he felt confident that the resident could handle the small trip to and from the park entrance. The Recreational Therapist stated that Resident # 1 did not get a flag since he was not allowed past the park entrance at that time and would not be in the neighborhood. An interview was conducted with Receptionist (Staff #59) on May 5, 2026 at 12:34 p.m., who stated that anytime someone leaves the facility they sign the log book and document the time they left. The receptionist stated that Resident # 1 usually stayed out in the front of the building or by the entrance to the park to talk with the other residents. The receptionist stated that on May 1, 2026 at 8:10 a.m. Resident # 1 was in hurry to sign out not saying anything and he wheeled out to the front portico where she last saw him. The receptionist further stated that when she was getting ready to go on break at 9:15 a.m. she went out front to the portico to put eyes on the residents and that is when she noticed that Resident # 1 was not in the portico or the entrance to the park. The receptionist stated that she called the nurses station to verify that the resident had not returned and staff denied that the resident was upstairs. She stated she called a Code Pink indicating to staff there is a missing resident. The receptionist stated that during a Code Pink staff come to the front desk and get a copy of the resident's picture and are assigned an area in the neighborhood to look. The receptionist stated that she was alerted by management that the (continued on next page)

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