

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/28/2026
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)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, State Agency (SA) complaint/incident tracking system, resident and staff interviews, and policy review, the facility failed to implement written policies and procedures to prevent, report, and investigate an allegation of sexual abuse for one of three sampled residents (#67). The census was 95. The deficient practice could result in corrective actions not being taken and residents being further abused. Findings include: Resident #67 was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, testicular hypofunction, depression, hypothyroidism, anemia, hypertension, and age-related osteoporosis. A quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated intact cognition. A request was made on July 28, 2026, at 12:45 p.m. for the incident report/facility investigation, which revealed two undated staff statements. One of the signed statements was handwritten by a certified nursing assistant (CNA/Staff#2), who overheard a CNA saying that a resident had pictures of a staff member, and that they were laughing about it, but that he thought it was enough to report to the administrator. The second signed statement was typed by the administrator, Staff #25, and revealed that the CNA, Staff #2, reported that he heard a rumor that Resident #67 had inappropriate pictures on his phone of another CNA, Staff #32. The statement further revealed that upon hearing that information, the administrator spoke to Resident #67 to see if he had any pictures on his phone, to which the resident reported that Adult Protective Services (APS) was there the week before to ask him the same questions, and denied that he had the photos. The statement further revealed that the facility knew APS was out to see him the week before, but they did not know why they were out to see him. A request was made on July 28, 2026, at 12:45 p.m. for the incident timeline, and the administrator signed that the allegation was reported to the NHA, nursing home administrator, on 6/30/2025. An interview was conducted on July 28, 2026, at 9:22 a.m. with the Registered Nurse Supervisor (RN Supervisor/Staff#22), who stated that the timeframe for reporting an allegation of abuse was within 2 hours to the administrator, police, and the ombudsman if it was reported to her or if she witnessed it. The RN supervisor stated that an allegation of a staff member sending or selling inappropriate photos to a resident would absolutely be considered sexual abuse. The RN supervisor also stated that she heard someone say that a resident had explicit material on his laptop of a staff member, and that she identified the resident as Resident #67. The RN supervisor stated that it was investigated by the state and reported within the last month. The RN supervisor stated that Adult Protective Services (APS) also investigated the incident and that she learned about it when the resident approached her and asked the nurse if she heard what happened. The nurse stated that the resident reported to her that APS went to see him, asked about pictures on his computer or if he had inappropriate pictures of a staff member, and that the resident told them he didn't. An interview was (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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted on July 28, 2026, at 9:49 a.m. with Resident #67, who stated that he had not received any photos from staff members and that another state agency had come in to speak with him about the same matter a few weeks prior. An interview was conducted on July 28, 2026, at 10:13 a.m. with a registry CNA (CNA/Staff#47), who stated that the timeframe for reporting an allegation of abuse was 2 hours. The CNA stated that an allegation of a staff member sending or selling an inappropriate photo of themselves to a resident would be sexual abuse, and that she had heard a rumor by another CNA, Staff #85, that another CNA, Staff #32, was fired from the building for showing a resident pictures of herself, but did not know if the CNA was nude or in a bikini in the photos. The CNA, Staff #47, also stated that she did not know if the rumor about the inappropriate photos was reported, but that Staff #85 made it sound like facility administration knew about it. An interview was conducted on July 28, 2026, at 10:24 a.m. with a registry CNA (CNA/Staff#85), who stated that the timeframe for reporting an allegation of abuse was immediately, and that an allegation of a staff member sending or selling inappropriate photos of themselves to a resident would be sexual abuse. The CNA stated that she had not heard of that happening at the facility, but that there was a rumor regarding another CNA upstairs, but that she did not want to spread rumors. The CNA further stated that the director of nursing (DON/Staff #8) and administrator (Administrator/Staff #25) could provide an answer about the inappropriate photos better than she could. The CNA stated that the allegation was made about a former CNA, Staff #32, she did not know which resident was involved, she did not know the timeframe for the allegation, and she did not believe that the allegation happened. An interview was conducted on July 28, 2026, at 10:39 a.m. with a former CNA (former CNA/Staff#32), who stated that the timeframe for reporting an allegation of abuse was 2 hours to her supervisor, and that sexual abuse was defined as inappropriate behaviors, communications, or boundaries with a resident. The CNA also stated that an allegation of staff sending or selling inappropriate photos of themselves to residents would be sexual abuse. The CNA stated that she had not sent any photos of herself to a resident. A follow-up interview was conducted on July 28, 2026, at 10:51 a.m. with the former CNA, Staff #32, who stated that she recalled more information about the allegation, and that her agency called her on June 22, 2026, asking if she had sent pictures of herself to a resident for compensation, and the CNA told them no and immediately reported the information to the administrator, Staff #25, who told her that the agency did not inform her before calling the Staff #32. The CNA stated that after she spoke to the administrator, no one ever contacted her again about the allegation, and she knew nothing else. The CNA further stated that she was terminated by the facility on June 30, 2026, because of the sexual abuse rumors, employee complaints, and APS complaints regarding her care for residents. An interview was conducted on July 28, 2026, at 11:08 a.m. with the director of nursing, Staff #8, who stated that the timeframe for reporting an allegation of abuse was 2 hours, and that administration or floor staff had to report to the Arizona Department of Health Services (AZDHS), police, APS, the ombudsman, the provider, and the administrator within that timeframe. The DON stated that sexual abuse was defined as any unwanted physical, mental, or emotional contact that was unwanted by another party, and that an allegation of a staff member sending or selling inappropriate photos of themselves to a resident would be sexual abuse if it was unwanted, and then corrected herself and stated that an allegation of that nature would be inappropriate, but it would be a fine line if it would be considered sexual abuse. The DON corrected herself again and stated that if that allegation of inappropriate photos being sent or sold to residents occurred in the facility, it would be considered sexual abuse. The DON stated that the facility did have an allegation of a CNA, Staff #32, sending inappropriate photos of herself to a resident, and that APS had come out before they were alerted to it. The DON also stated that the facility did not report the allegation to anyone, because when the (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility investigated the allegation and questioned the resident, he denied having photos of the staff member on his device. The DON stated that they became aware of the allegation a couple of weeks after APS came out, which was the same day that they terminated the accused CNA, Staff #32, which was 3-4 weeks ago; however, the DON later stated that the CNA was not immediately terminated, and that she continued working for 2 weeks after they found out. The DON stated that they decided to terminate the CNA for bullying, sending nude photos to another staff member, and choking another CNA. The DON stated that they were told somehow that the CNA, Staff #32, had been accused of sending a resident inappropriate pictures, but she did not recall how it was brought up or who said it. The DON stated that the purpose of reporting an allegation of abuse was to make the state aware, notify the authorities, and to have the allegation investigated, but that they failed to report the allegation of abuse. The DON stated that it would be the facility's expectation to have reported the allegation, and that the risk of failing to report, investigate, and implement their abuse policy for an allegation of abuse would be multiple citations, additional abuse occurrences, ongoing abuse to the resident, and mental, emotional, and physical impacts to the resident such as withdrawal. The DON also stated that they did have a full investigation of the incident that was documented with statements, but that they did not report it because they did not see it as an allegation of abuse due to the resident denying having the photos. An interview was conducted on July 28, 2026, at 11:30 a.m. with the administrator, Staff #25, who stated that the timeframe for reporting an allegation of abuse was 2 hours, but ideally, immediately, to AZDHS, APS, the police, the ombudsman, the physician, and the case manager if applicable. The administrator stated that sexual abuse was defined as unwanted advances, including touching and verbal. The administrator stated that all allegations of sexual abuse would be reportable, and that an allegation of a staff member sending or selling inappropriate pictures of themselves being reportable would depend on what the photos were of. The administrator stated that an allegation of a staff member sending pictures of their breasts would be inappropriate, but she would need to do a small investigation to see if the allegation was founded, and if it was, she would report it. The administrator further stated that she would do the small investigation before their 2-hour reporting window was up, and that in the instance that we would be discussing, she asked the individual, Resident #67, if he had pictures of a staff member on his phone, and he denied having pictures. The administrator stated that a staff member told her through the grapevine that the resident had pictures on his phone that were inappropriate, and stated that they did not report the allegation to anyone. The administrator stated that they did not speak with any other residents or staff members about the alleged incident and that their policy was to interview all of the people involved if the allegation was reportable, but in this case, there was nothing to report and she did not know who she was going to interview. The administrator stated that the purpose of reporting an allegation of abuse to the applicable state agencies was to allow more time for them to investigate, because 2 hours was not a lot of time to investigate. The administrator stated that the facility's expectation for investigating an allegation of abuse would be to interview the resident, gather statements from staff members involved, write up a final investigation, and submit the investigation to AZDHS and the ombudsman. The administrator also stated that the facility's expectation for reporting any allegation of abuse would be immediately, or within 2 hours. The administrator stated that the risk of failing to report, investigate, and implement their policy for an allegation of abuse would be possibly putting other residents in danger. Review of a policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2026, revealed that the facility had an abuse prevention program that consisted of developing and implementing policies and protocols to prevent and identify abuse or mistreatment of residents. The policy also revealed that the facility (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would identify and investigate all possible incidents of abuse, and report any allegations within timeframes required by federal requirements. The policy also revealed that the facility would protect residents from any further harm during investigations. Review of a policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated April 2026, revealed that all reports of resident abuse would be reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy further revealed that findings of all investigations would be documented and reported. The policy also revealed that if resident abuse was suspected, the suspicion had to be reported immediately to the administrator and to other officials, according to state law. The policy also revealed that the administrator or the individual making the allegation would immediately report his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the resident's representative, adult protective services (where state law provides jurisdiction in long-term care), law enforcement officials, the resident's attending physician, and the facility medical director. The policy revealed that immediately was defined as within 2 hours of an allegation involving abuse, and that verbal or written notices to agencies would be submitted via special carrier, fax, e-mail, or by telephone. The policy further revealed that notices would include the resident's name, the resident's room number, the type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.), the date and time the alleged incident occurred, the name(s) of all persons involved in the alleged incident, and what immediate action was taken by the facility. Continue review of a policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated April 2026, revealed that all allegations would be thoroughly investigated, and that any employee who was accused of resident abuse would be placed on leave with no resident contact until the investigation was completed. The policy also revealed that, at a minimum, the individual conducting the investigation would need to review the documentation and evidence, review the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident, observe the alleged victim, including his or her interactions with staff and other residents, interview the person(s) reporting the incident, interview any witnesses to the incident, interview the resident (as medically appropriate) or the resident's representative, interview the resident's attending physician as needed to determine the resident's condition, interviews staff members (on all shifts) who had contact with the resident during the period of the alleged incident, interview the resident's roommate, family members, and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to the alleged incident, and document the investigation completely and thoroughly. The policy further revealed that each interview would need to be conducted separately and in a private location, and that the purpose and confidentiality of the interview would be explained thoroughly to each person involved in the interview process. The policy revealed that witness statements would be obtained in writing, signed and dated, and that the witness was permitted to write his/her statement, or the investigator would obtain a statement. The policy also revealed that the investigator would notify the ombudsman that an abuse investigation was being conducted, and the ombudsman would be invited to participate in the review process. The policy revealed that any allegations of abuse were filed in the accused employee's personnel record along with any statement by the employee disputing the allegation, if the employee chose to make one.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, State Agency (SA) complaint/incident tracking system, resident and staff interviews, and policy review, the facility failed to report an allegation of sexual abuse within the required timeframe for one of three sampled residents (#67). The census was 95. The deficient practice could result in corrective actions not being taken and residents being further abused. Findings include: Resident #67 was admitted to the facility on [DATE], with diagnoses of hemiplegia, hemiparesis, testicular hypofunction, and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The assessment also documented that the resident was negative for indicators of psychosis and behavioral symptoms. The SA complaint/incident tracking system revealed that another state agency submitted a report on July 24, 2026, alleging sexual abuse and exploitation of a vulnerable adult identified as resident #67. The complaint alleged that a staff member was sending the resident explicit content in exchange for money. A request was made on July 28, 2026, at 12:45 p.m. for the incident report/facility investigation, which revealed two undated staff statements. One of the signed statements was handwritten by a certified nursing assistant (CNA/Staff#2), who overheard a CNA saying that a resident had pictures of a staff member, and that they were laughing about it, but that he thought it was enough to report to the administrator. The second signed statement was typed by the administrator, Staff #25, and revealed that the CNA, Staff #2, reported that he heard a rumor that Resident #67 had inappropriate pictures on his phone of another CNA, Staff #32. The statement further revealed that upon hearing that information, the administrator spoke to Resident #67 to see if he had any pictures on his phone, to which the resident reported that Adult Protective Services (APS) was there the week before to ask him the same questions, and denied that he had the photos. The statement further revealed that the facility knew APS was out to see him the week before, but they did not know why they were out to see him. A request was made on July 28, 2026, at 12:45 p.m. for the incident timeline, and the administrator signed that the allegation was reported to the NHA, nursing home administrator, on 6/30/2025. Further review of the SA complaint/incident tracking system on July 28, 2026, revealed no evidence that the facility had reported the allegation to the SA. An interview was conducted on July 28, 2026, at 9:22 a.m. with the Registered Nurse Supervisor (RN Supervisor/Staff #22), who stated that an allegation of abuse has to be reported within 2 hours to the administrator, police, and the ombudsman. Per the RN supervisor, an allegation of a staff member sending or selling inappropriate photos to a resident would absolutely be sexual abuse. The RN supervisor also stated that she heard someone say that Resident #67 had explicit material on his laptop of a staff member, but she could not recall who had told her or what date she found out. According to the RN supervisor, it was investigated by the state and reported within the last month, so she did not report it. The RN supervisor said that Resident #67 informed her that another state agency also investigated the incident. The nurse stated that the resident informed her that the other state agency inquired about pictures on his computer or if he had inappropriate pictures of a staff member, and that the resident indicated that he had none in his possession. The RN supervisor stated that her conversation with the resident about his encounter with the other state agency occurred at the beginning of July 2026. An interview was conducted on July 28, 2026, at 9:49 a.m. with Resident #67. The resident denied having any photos from staff members. Per the resident, another state agency had come in to speak with him about the same (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	matter a few weeks prior. During an interview with a registry CNA (Staff #47) conducted on July 28, 2026, at 10:13 a.m., Staff #47 stated that an allegation of abuse had to be reported within 2 hours. The CNA said that an allegation of a staff member sending or selling an inappropriate photo to a resident would be sexual abuse. Additionally, the CNA indicated she heard a rumor from Staff #85 (CNA) that Staff #32 was fired for showing a resident pictures of herself. However, she was unsure if the photos were nude or bikini shots. Staff #47 noted that she did not know if the rumor about the inappropriate photos was reported. Staff #47 commented that Staff #85 made it sound like the facility administration knew about it. An interview was conducted on July 28, 2026, at 10:24 a.m. with a registry CNA (Staff #85), who stated that an allegation of abuse had to be reported immediately. Per Staff #85, an allegation of a staff member sending or selling inappropriate photos to a resident would be sexual abuse. The CNA denied having knowledge of such incidents occurring at the facility. However, she acknowledged hearing about another CNA upstairs but was unsure if it was true. The CNA further stated that the director of nursing (DON/Staff #8) and administrator (Administrator/Staff #25) could provide an answer about the inappropriate photos better than she could. The CNA stated that the allegation was made about a former CNA, Staff #32. However, she is unaware which resident was involved. Additionally, she did not know the timeframe for the allegation, and did not believe that the allegation happened. An interview was conducted on July 28, 2026, at 10:39 a.m. with a former CNA (Staff #32/alleged perpetrator). Staff #32 stated that an allegation of abuse had to be reported within 2 hours to the supervisor, and that sexual abuse was defined as inappropriate behaviors, communications, or boundaries with a resident. The CNA said that an allegation of staff sending or selling inappropriate photos of themselves to residents would be sexual abuse. The CNA denied sending any photos of herself to a resident. A follow-up interview with Staff #32 was conducted on July 28, 2026, at 10:51 a.m. Staff #32 stated that her agency called her on June 22, 2026, and questioned whether she sent pictures of herself to a resident for compensation. Staff #32 denied the allegation and immediately reported the information to the administrator (Staff #25). The administrator told her that the agency did not inform her before calling Staff #32. After her conversation with the administrator, no one ever contacted her again about the allegation, and she knew nothing else. Staff #32 admitted that she was terminated by the facility on June 30, 2026, because of the sexual abuse rumors, employee complaints, and state agency complaints regarding her care for residents. An interview was conducted on July 28, 2026, at 11:08 a.m. with the director of nursing (DON/Staff #8). Per the DON, an allegation of abuse had to be reported within 2 hours. Additionally, the administration or floor staff had to report the allegation to outside organizations such as the SA police, the ombudsman, the provider, and the administrator within that timeframe. The DON stated that sexual abuse was defined as any unwanted physical, mental, or emotional contact that was unwanted by another party. The DON said that an allegation of a staff member sending or selling inappropriate photos to a resident would be sexual abuse if it was unwanted, and then clarified that an allegation of that nature would be inappropriate, but it would be a fine line if it would be considered sexual abuse. The DON then stated that if that allegation of inappropriate photos being sent or sold to residents occurred in the facility, it would be considered sexual abuse. The DON admitted that there was an allegation of Staff #32 sending inappropriate photos of herself to a resident, and that another state agency had come out before they were alerted to it. The DON also admitted that the facility did not report the allegation to anyone, because when the facility investigated the allegation and questioned the resident, he denied having photos of the staff member on his device. The DON stated that they became aware of the allegation a couple of weeks after the other state agency visited, which was the same day that they terminated the accused CNA, Staff #32. The DON said this was (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately 3-4 weeks ago. However, the DON later acknowledged that the CNA was not immediately terminated, and that she continued working for 2 weeks after they found out. The DON said they terminated the CNA for bullying, sending nude photos to another staff member, and choking another CNA. The DON said they were told somehow that Staff #32 was accused of sending a resident inappropriate pictures, but do not recall how it was brought up or who said it. The DON stated that the purpose of reporting an allegation of abuse was to make the state aware, notify the authorities, and to have the allegation investigated., The DON admitted that they failed to report the allegation of abuse, and that they did not follow their abuse policy, which would have been to report the allegation within 2 hours. The DON said it was the facility's expectation to have reported the allegation, and that the risk of failing to report, investigate, and implement their abuse policy for an allegation of abuse would be multiple citations, additional abuse occurrences, ongoing abuse to the resident, and mental, emotional, and physical impacts to the resident such as withdrawal. The DON also stated that they did have a full investigation of the incident that was documented with statements, but that they did not report it because they did not see it as an allegation of abuse because the resident denied having the photos. An interview was conducted on July 28, 2026, at 11:30 a.m. with the administrator (Staff #25), who stated that an allegation of abuse had to be reported within 2 hours, but ideally, immediately, to the state agencies, the police, the ombudsman, the physician, and the case manager if applicable. The administrator stated that sexual abuse was defined as unwanted advances, including touching and verbal. The administrator stated that all allegations of sexual abuse would be reportable. Additionally, an allegation of a staff member sending or selling inappropriate pictures of themselves would be reportable depending on the photos' content. The administrator said that an allegation of a staff member sending pictures of their breasts would be inappropriate, but she would need to do a small investigation to see if the allegation was founded, and if it was, she would report it. The administrator further stated that she would do the small investigation before their 2-hour reporting window was up, and that in the instance that we would be discussing, she asked Resident #67 if he had pictures of a staff member on his phone, and he denied having pictures. The administrator stated that a staff member told her through the grapevine that the resident had pictures on his phone that were inappropriate, and she admitted that they did not report the allegation to anyone. The administrator also admitted that they did not speak with any other residents or staff members about the alleged incident and that their policy was to interview all of the people involved if the allegation was reportable, including the resident and staff members. However, in this case, there was nothing to report and she did not know who she was going to interview. The administrator stated that the purpose of reporting an allegation of abuse to the applicable state agencies was to allow more time for them to investigate, because 2 hours was not a lot of time to investigate. The administrator stated that the facility's expectation for investigating an allegation of abuse would be to interview the resident, gather statements from staff members involved, write up a final investigation, and submit the investigation to the SA and the ombudsman. The administrator also stated that the facility's expectation for reporting any allegation of abuse would be immediately, or within 2 hours. The administrator stated that the risk of failing to report, investigate, and implement their policy for an allegation of abuse would be possibly putting other residents in danger. The facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2026, revealed that residents have the right to be free from abuse and exploitation. Per their policy, it is the facility's objective to protect residents from abuse and exploitation. Additionally, the policy directed the facility to develop and implement policies and protocols to prevent and identify abuse and exploitation of residents. The policy also noted that the facility would identify and investigate all (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible incidents of abuse, and report any allegations within timeframes required by federal requirements. Per the policy, the facility would protect residents from any further harm during investigations. The policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated April 2026, indicated that all reports of resident abuse and exploitation would be reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Additionally, findings of all investigations would be documented and reported. Per the policy, if resident abuse was suspected, the suspicion had to be reported immediately to the administrator and to other officials, according to state law. Immediately was defined as within two hours of an allegation involving abuse. The policy directed the administrator or the individual making the allegation to immediately report his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the resident's representative, where state law provides jurisdiction in long-term care, law enforcement officials, the resident's attending physician, and the facility medical director. Furthermore, verbal or written notices to agencies would be submitted via special carrier, fax, e-mail, or by telephone. The policy further revealed that notices would include the resident's name, the resident's room number, the type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.), the date and time the alleged incident occurred, the name(s) of all persons involved in the alleged incident, and what immediate action was taken by the facility. Per the policy, any employee who was accused of resident abuse would be placed on leave with no resident contact until the investigation was completed. The policy noted that the individual conducting the investigation would need to review the documentation and evidence, review the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident, observe the alleged victim, including his or her interactions with staff and other residents, interview the person(s) reporting the incident, interview any witnesses to the incident, interview the resident (as medically appropriate) or the resident's representative, interviews staff members (on all shifts) who had contact with the resident during the period of the alleged incident, interview the resident's roommate, family members, and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to the alleged incident, and document the investigation completely and thoroughly. Per the policy, witness statements would be obtained in writing, signed and dated, and the witness was permitted to write his/her statement, or the investigator would obtain a statement. The policy also revealed that the investigator would notify the ombudsman that an abuse investigation was being conducted, and the ombudsman would be invited to participate in the review process. The policy revealed that any allegations of abuse were filed in the accused employee's personnel record along with any statement by the employee disputing the allegation, if the employee chose to make one.		

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 07/28/2026
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.			
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, State Agency (SA) complaint/incident tracking system, resident and staff interviews, and policy review, the facility failed to thoroughly investigate an allegation of sexual abuse for one of three sampled residents (#67). The census was 95. The deficient practice could result in corrective actions not being taken and residents being further abused. Findings include: Resident #67 was admitted to the facility on [DATE], with diagnoses of hemiplegia, hemiparesis, testicular hypofunction, and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The assessment also documented that the resident was negative for indicators of psychosis and behavioral symptoms. The SA complaint/incident tracking system revealed that another state agency submitted a report on July 24, 2026, alleging sexual abuse and exploitation of a vulnerable adult identified as resident #67. The complaint alleged that a staff member was sending the resident explicit content in exchange for money. A request was made on July 28, 2026, at 12:45 p.m. for the incident report/facility investigation, which revealed two undated staff statements. One of the signed statements was handwritten by a certified nursing assistant (CNA/Staff#2), who overheard a CNA saying that a resident had pictures of a staff member, and that they were laughing about it, but that he thought it was enough to report to the administrator. The second signed statement was typed by the administrator, Staff #25, and revealed that the CNA, Staff #2, reported that he heard a rumor that Resident #67 had inappropriate pictures on his phone of another CNA, Staff #32. The statement further revealed that upon hearing that information, the administrator spoke to Resident #67 to see if he had any pictures on his phone, to which the resident reported that Adult Protective Services (APS) was there the week before to ask him the same questions, and denied that he had the photos. The statement further revealed that the facility knew APS was out to see him the week before, but they did not know why they were out to see him. There were no additional investigative documentation provided for review during the survey. An interview was conducted on July 28, 2026, at 9:22 a.m. with the Registered Nurse Supervisor (RN Supervisor/Staff #22), who stated that she heard someone say that Resident #67 had explicit material on his laptop of a staff member, but she could not recall who had told her or what date she found out. According to the RN supervisor, it was investigated by the state and reported within the last month. The RN supervisor said that Resident #67 informed her that another state agency also investigated the incident. The nurse stated that the resident informed her that the other state agency inquired about pictures on his computer or if he had inappropriate pictures of a staff member, and that the resident indicated that he had none in his possession. The RN supervisor stated that her conversation with the resident about his encounter with the other state agency occurred at the beginning of July 2026. An interview was conducted on July 28, 2026, at 9:49 a.m. with Resident #67. The resident denied having any photos from staff members. Per the resident, another state agency had come in to speak with him about the same matter a few weeks prior. During an interview with a registry CNA (Staff #47) conducted on July 28, 2026, at 10:13 a.m., Staff #47 stated that she heard a rumor from Staff #85 (CNA) that Staff #32 was fired for showing a resident pictures of herself. However, she was unsure if the photos were nude or bikini shots. Staff #47 noted that she did not know if the rumor about the inappropriate photos was reported or investigated. Staff #47 commented that Staff #85 made it sound like the facility administration knew about it. An interview was conducted on July 28, 2026, at 10:24 a.m. with a registry CNA (Staff #85), who denied having knowledge of such (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incidents occurring at the facility; however, she acknowledged hearing something similar about another CNA upstairs but was unsure if it was true. The CNA further stated that the director of nursing (DON/Staff #8) and administrator (Administrator/Staff #25) could provide an answer about the inappropriate photos better than she could. The CNA stated that the allegation was made about a former CNA, Staff #32. However, she was unaware which resident was involved. Additionally, she did not know the timeframe for the allegation, and did not believe that the allegation happened. An interview was conducted on July 28, 2026, at 10:39 a.m. with a former CNA (Staff#32/alleged perpetrator), who stated that sexual abuse was defined as inappropriate behaviors, communications, or boundaries with a resident. The CNA said that an allegation of staff sending or selling inappropriate photos of themselves to residents would be sexual abuse. The CNA denied sending any photos of herself to a resident. A follow-up interview with Staff #32 was conducted on July 28, 2026, at 10:51 a.m. Staff #32 stated that her agency called her on June 22, 2026, and questioned whether she sent pictures of herself to a resident for compensation. Staff #32 stated that she denied the allegation and immediately reported the information to the administrator (Staff #25). The administrator told her that the agency did not inform her before calling Staff #32. Staff #32 stated that after her conversation with the administrator, no one ever contacted her again about the allegation, and she knew nothing else. Staff #32 admitted that she was terminated by the facility on June 30, 2026, because of the sexual abuse rumors, employee complaints, and state agency complaints regarding her care for residents. An interview was conducted on July 28, 2026, at 11:08 a.m. with the director of nursing (DON/Staff #8), who stated that an allegation of a staff member sending or selling inappropriate photos to a resident would be sexual abuse if it was unwanted, and then clarified that an allegation of that nature would be inappropriate, but it would be a fine line if it would be considered sexual abuse. The DON then stated that if that allegation of inappropriate photos being sent or sold to residents occurred in the facility, it would be considered sexual abuse. The DON admitted that there was an allegation of Staff #32 sending inappropriate photos of herself to a resident, and that another state agency had come out before they were alerted to it. The DON also admitted that the facility did not report the allegation to anyone, because when the facility investigated the allegation and questioned the resident, he denied having photos of the staff member on his device. The DON stated that they became aware of the allegation a couple of weeks after the other state agency visited, which was the same day that they terminated the accused CNA, Staff #32. The DON said this was approximately 3-4 weeks ago. However, the DON later acknowledged that the CNA was not immediately terminated, and that she continued working for 2 weeks after they found out. The DON said they terminated the CNA for bullying, sending nude photos to another staff member, and choking another CNA. The DON stated that they were told somehow that Staff #32 was accused of sending a resident inappropriate pictures, but did not recall how it was brought up or who said it. The DON stated that the purpose of reporting an allegation of abuse was to make the state aware, notify the authorities, and to have the allegation investigated. The DON said it was the facility's expectation to have investigated the allegation, and that the risk of failing to investigate an allegation of abuse would be multiple citations, additional abuse occurrences, ongoing abuse to the resident, and mental, emotional, and physical impacts to the resident such as withdrawal. The DON also stated that they did have a full investigation of the incident that was documented with statements, but that they did not report it because they did not see it as an allegation of abuse because the resident denied having the photos; however, there was no evidence provided by the facility to show that a full investigation had been conducted per the facility policy. An interview was conducted on July 28, 2026, at 11:30 a.m. with the administrator (Staff #25), who stated that sexual abuse was defined as unwanted advances, including touching and verbal. The (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administrator stated that all allegations of sexual abuse would be reportable. Additionally, an allegation of a staff member sending or selling inappropriate pictures of themselves would be reportable depending on the photos' content. The administrator said that an allegation of a staff member sending pictures of their breasts would be inappropriate, but she would need to do a small investigation to see if the allegation was founded, and if it was, she would report it. The administrator further stated that she would do the small investigation before their 2-hour reporting window was up, and that in the instance that we would be discussing, she asked Resident #67 if he had pictures of a staff member on his phone, and he denied having pictures. The administrator stated that a staff member told her through the grapevine that the resident had pictures on his phone that were inappropriate, and she admitted that they did not speak with any other residents or staff members about the alleged incident and that their policy was to interview all of the people involved if the allegation was reportable, including the resident and staff members. The Administrator stated that in this case, there was nothing to report and she did not know who she was going to interview. The Administrator stated that the purpose of reporting an allegation of abuse to the applicable state agencies was to allow more time for them to investigate, because 2 hours was not a lot of time to investigate. The administrator stated that the facility's expectation for investigating an allegation of abuse would be to interview the resident, gather statements from staff members involved, write up a final investigation, and submit the investigation to the SA and the ombudsman. The administrator stated that the risk of failing to investigate an allegation of abuse would be possibly putting other residents in danger. Review of a policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2026, revealed that the facility had an abuse prevention program that consisted of developing and implementing policies and protocols to prevent and identify abuse or mistreatment of residents. The policy also revealed that the facility would identify and investigate all possible incidents of abuse. The policy also revealed that the facility would protect residents from any further harm during investigations. Review of a policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated April 2026, revealed that all allegations would be thoroughly investigated, and that any employee who was accused of resident abuse would be placed on leave with no resident contact until the investigation was completed. The policy also revealed that, at a minimum, the individual conducting the investigation would need to review the documentation and evidence, review the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident, observe the alleged victim, including his or her interactions with staff and other residents, interview the person(s) reporting the incident, interview any witnesses to the incident, interview the resident (as medically appropriate) or the resident's representative, interview the resident's attending physician as needed to determine the resident's condition, interviews staff members (on all shifts) who had contact with the resident during the period of the alleged incident, interview the resident's roommate, family members, and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to the alleged incident, and document the investigation completely and thoroughly. The policy further revealed that each interview would need to be conducted separately and in a private location, and that the purpose and confidentiality of the interview would be explained thoroughly to each person involved in the interview process. The policy revealed that witness statements would be obtained in writing, signed and dated, and that the witness was permitted to write his/her statement, or the investigator would obtain a statement. The policy also revealed that the investigator would notify the ombudsman that an abuse investigation was being conducted, and the ombudsman would be invited to participate in the review process. The policy revealed that any allegations of abuse were (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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