STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035284	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Tucson	555 East Ajo Way Tucson, AZ 85713

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and review of the facility's policies and procedures, the facility failed to ensure one resident (#1) was free from verbal abuse from visitors. The deficient practice could lead to physical and psychosocial harm to residents.Findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses that included encounter for palliative care, pneumonia, and urinary tract infection (UTI).Review of the Quarterly Minimum Data Set (MDS), dated [DATE], indicated that a Brief Interview for Mental Status (BIMS) was not able to be completed. However, staff assessed Resident #1's cognitive skills for daily decision making to be severely impaired. The same MDS did not indicate Resident #1 exhibited behaviors of any type.Review of the clinical record revealed Progress Note dated May 23, 2023 at 3:03 P.M. that indicated Resident #1 had a caregiver at bedside. The note further indicated that a CNA (Certified Nursing Assistant) reported the resident had bitten the caregiver on the right 2nd finger during care.Review of additional progress notes revealed an entry dated May 23, 2023 at 5:11 P.M. The entry indicated that a CNA (Certified Nursing Assistant) had reported that Resident #1's caregiver had put soap in his mouth because he was cursing. It also indicated that was the reason Resident #1 had bitten the caregiver. It further indicated that the house supervisor was notified of the incident.An interview was conducted with CNA/Staff #6 on December 26, 2025 at 1:32 P.M. Staff #6 explained that because he works with Veterans, they tend to swear a lot or swear at him. However, he added it did not mean that you can retaliate towards them. When asked if putting soap in a resident's mouth would constitute as abuse, he said yes.A telephonic interview was conducted on December 26, 2025 at 2:25 with the caregiver (alleged perpetrator). The caregiver indicated that she was hired by his wife as a companion caregiver to help with cleaning and feeding Resident #1. However, she stated that she did not really recall the resident but remembered the wife. She further stated that there was some sort of disagreement, but she couldn't recall what, that led to her not working with the family anymore. The caregiver added that she had short-term memory loss so she does not remember a lot of things.An interview was conducted with the Director of Nursing (DON/Staff #49) on December 26, 2025 at 2:34 P.M. Staff #49 explained that the facility self-reported the incident when Resident #1's caregiver had reported to the CNA that they had a verbal altercation and she was not happy with the words he had used. Staff #49 further explained that the caregiver reported telling Resident #1 to be nice and to stop saying vulgar words and if he didn't stop, she told him that people who curse get their mouths washed out with soap. The caregiver had soap on her hands and then Resident #1 lunged forward and bit the soap in the caregiver's hands along with her fingers. Staff #49 shared that after the incident came to light the facility informed the caregiver that she was no longer welcome at the facility. Staff #49 indicated that it was not acceptable for visitors to threaten to put soap into the mouths of residents as it would cause mental anguish to those on the receiving end and they could also feel threatened.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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the Administrator/Staff #12 on December 26, 2025 at 2:53 P.M. He acknowledged that he was the abuse coordinator for the facility. Staff #12 shared that the friend of the family would visit and sit with Resident #1. At one point, the friend had threatened to wash Resident #1's mouth out with soap, however, he was not sure if the friend actually did it or not. He did indicate that Resident #1 did bite the visitor. Staff #12 further indicated that the friend was banned from the facility and the situation was reported to the SA and the local police department. Staff #12 explained that Resident #1 was not able to communicate and he had advanced Parkinson's disease so Staff #12 was not able to get a statement from the resident regarding the incident. When asked if it was acceptable for visitors to threaten putting soap into residents' mouths, Staff #12 shared that it was absolutely not acceptation which is why the friend was banned from the facility. He further shared that he was not comfortable with speculating what harm could come from the residents when they are threatened. However, he pointed out that the facility does not allow that type of behavior and if someone were acting like that, they are not allowed to stay at the facility.Review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation - Prevention Program, indicated the policy was revised in January 2025. The policy indicated that residents have a right to be free from abuse, neglect. It also includes verbal and physical abuse as well.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, resident, family, and staff interviews, and review of the facility's policies and procedures, the facility failed to protect rights of one resident (resident #10) to be free from misappropriation from staff. The deficient practice could result in further incidents of staff to resident financial abuse. Findings include: -Resident #10 was admitted to the facility on [DATE], with diagnoses that include Bradycardia, atrial fibrillation, bipolar disorder, anxiety, dementia, and peripheral vascular disease. Review of the Significant change Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had no cognitive impairment. A review of the SA(state agency) complaint system revealed that on June 18, 2024 at 10:00 a.m. an incident was reported by the facility that resident #10 had reported to her nurse, she had been asked for money by a previous employee (staff #75) that had recently quit the facility. It revealed that the staff #75 picked resident #10 up for lunch and that resident #10 had filled the employee's gas tank for $55, and paid for lunch for $35. It further revealed that after returning to the facility staff #75 asked for $1200, and that resident #10 initially declined but agreed because she felt pressured to give him the money, after which staff #75 had her download the banking app [NAME] on her phone and sent the $1200 to his account. It concluded that resident #10 stated this is not the first instance of giving staff #75 money. An interview was conducted with resident #10 on December 26, 2025 at 1:10 p.m. Resident #10 stated staff #75 started asking for money, for a lot of things. She stated that initially she thought staff #75 didn't make much money and felt sorry for the guy. She stated that she would help the guy as much as she could, and that staff #75 wanted money for rent, but kept buying things like laptops and stuff, and not paying his rent. Resident #10 stated that the icing on the cake was he showed up asking for $1200 to pay his rent and said we can do it through [NAME]. She continued that staff #75 stated he needed the money for his rent. Resident #10 stated that after the [NAME] transaction went through she got a call from the bank to confirm the transaction and she did. She further stated that later she reported the incident and the police got involved, which also involved the administrator who told resident #10 she couldn't give money to employees. Resident #10 stated that she never got the money back, and that the facility never reimbursed any of the money she lost. Resident #10 concluded that she was told by staff #75 that he was going to pay the money back, but never did. Resident #10 concluded that she spoke to staff #75 and he told her that resident #10 got him in trouble with the police, and stated that she did feel abused financially. An attempt to contact the perpetrator staff #75 was attempted on December 26, 2025 at 1:35 p.m., however, the number was no longer valid. An interview with a Certified Nursing Assistant (CNA/staff #150) was conducted on December 29, 2025 at 1:32 p.m. Staff #150 stated that there are multiple kinds of abuse, physical, sexual, and financial. Staff #150 stated she was aware of an incident that had occurred and that they have had training that it wasn't appropriate to ask residents for gifts or to accept them. The CNA stated that it's never ok to ask residents for money or other gifts. Staff #150 concluded that the abuse coordinator is the administrator and that's who she would report abuse to if she saw it. An interview was conducted with the Director of Nursing (RN/staff #90) on December 29, 2026 at 3:20 p.m. The DON stated that she was aware of the incident when it occurred and after investigating it, found it to be substantiated. The DON then confirmed staff #75's name and provided a copy of the facility reported incident (FRI) related to the incident. The DON stated that staff #75 was previously employed by the facility and in the therapy department. The DON further stated that at the time of the incident he was no longer an employee at the time, and that (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident #10 had not been reimbursed. The DON further stated that they did training for staff and brought in the ombudsman during a resident council meeting to inform all the residents that they are not to be giving staff money or gratuity. The DON concluded that they did substantiated the complaint and made all the appropriate reports. A review of facility policy titled 'Abuse, Neglect, Exploitation and Misappropriation revised January, 2025 revealed that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.