

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/27/2024
NAME OF PROVIDER OR SUPPLIER  Arizona State Veteran Home - Yuma		STREET ADDRESS, CITY, STATE, ZIP CODE  6051 East 34th Street Yuma, AZ 85365	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932</b></p> <p>Based on clinical record review, interviews, facility documentation, and facility policy, the facility failed to ensure resident #1 was free from abuse from resident #3. The deficient practice can result in further instances of resident to resident abuse.</p> <p>Findings include:</p> <p>Related to resident #1-</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease, type 2 diabetes, and generalized muscle weakness.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated [DATE], reveals resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.</p> <p>A review of a progress note, dated December 15, 2024 at 7:50 A.M. was created by a Registered Nurse (RN/staff #81) went into detail about an incident that occurred that morning. It indicated that resident #1 was self-propelling himself from his room to the dining room when resident #3 threw coffee onto resident #1's lap for what seemed to be no reason at all other than 'moving too slow'. The note also indicated there were no injuries noted. The note also indicated that resident #2 had stepped in to defend resident #1, verbally, and was threatened by resident #3 when resident #3 said Fuck you, you're a piece of shit. I'm gonna kick your fucking ass. The writer of the note noted that she was able to redirect resident #2 and encourage him to leave the dining area. The progress note indicated that resident #1's wife was contacted and she requested to have charges filed due to her husband (resident #1) being bullied by resident #3 in the past.</p> <p>A progress note, dated December 16, 2024 at 11:15 AM, was created by Social Services (SS/Staff #30). The progress note indicated that Staff #30 met with resident #1 and he shared that he was doing well. The progress note also indicated that Resident #1 shared his concerns about how Resident #3 was treating him and other residents. Staff #30 encouraged Resident #1 to continue to share his concerns.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan was revised on December 15, 2024 to include a focus area related to resident #1's psychosocial wellbeing related to being free of injuries or assault caused by another resident. Interventions include observing for mood changes, offer emotionally support and reassurance of their safety, and maintaining a safe environment for the resident.</p> <p>Related to Resident #3-</p> <p>Resident #3 was admitted to the facility on [DATE] with diagnoses of hypertension, Stage 4 kidney disease, Post Traumatic Stress Disorder (PTSD), and Major Depressive Disorder.</p> <p>A review of the quarterly MDS, dated [DATE], revealed a BIMS score of 15 which indicated Resident #3 was cognitively intact.</p> <p>A progress note, dated December 15, 2024 at 8:36 A.M. was created by Staff #81. The progress note indicated that resident #3 threw a cup of coffee onto resident #1's lap, chest, and stomach. The note also indicated that resident #2 stood up for Resident #1 by asking Resident #3 what his problem was and he was rude and mean for what he did. Resident #3 verbally threatened Resident #2 by saying he was going to kick your fucking ass. All three residents were separated and redirected. The progress note also mentions that the security guard was made aware of the incident and saved a video recording of it. The note mentions that the security guard contacted Staff #81 and indicated they were sick to their stomach and that the situation was physical assault.</p> <p>A care plan was revised on December 15, 2024 to include a focus area of managing resident #3's behavioral symptoms of rage, physical assaultive behavior and aggressive behavior towards other residents and staff members. Interventions included having a monthly psychiatric assessment by in house psychiatry, offer counseling, setting healthy boundaries, and staff will monitor the resident closely for the safety of others.</p> <p>An interview was conducted on December 26, 2024 at 1:42 P.M. with Resident #3 in his room. When asked how he was getting along with other residents in the building, Resident #3 shared that he knew that question was coming and he also emphasized that he called Resident #1 a maggot, not a faggot. Resident #3 explained that the memory care unit in the facility was closed and he felt that there were several residents who should be in the memory care unit including resident #1. Resident #3 shared that Resident #1 had been in the facility for over a year and he felt that Resident #1 was a squirmy little worm who kept wandering around and doing whatever he wanted. Resident #3 also shared that Resident #1 was always coughing, was lazy and stupid to cover his mouth. He also explained that Resident #1 was always in his way. When asked if he ever did anything to hurt Resident #1, Resident #3 explained that Resident #1 was in his way when he was trying to get coffee and wouldn't move. He then decided to pour his cold coffee onto Resident #1's lap and added that he did not regret doing so.</p> <p>An interview was conducted on December 26, 2024 at 2:08 P.M. with Resident #1 and a family member who was visiting. When asked what transpired on December 15, 2024 in the breakfast area, Resident #1 indicated that a man threw his cold coffee at him. Resident #1 was not able to name Resident #3 but described him as a retired Jar Head ([NAME] Corp). When asked if he currently felt safe in the facility, Resident #1 indicated he did because they had moved the resident to another hall. The family member also shared that they had been having issues with Resident #3 for several months and had gotten social services involved because Resident #3 was bullying Resident #1 and other residents. The family member also shared that they had filed a police report as well.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on December 26, 2024 at 2:44 P.M. with Security (staff #6) at the front desk. Staff #6 was able to pull up security footage of the alleged incident between Resident #1 and Resident #3. Staff #6 was asked to explain what was happening in the surveillance video as it was being reviewed. Staff #6 indicated the incident took place at 7:12 AM on December 15, 2024 and he pointed to Resident #3, in the video, who was standing in front of Resident #1 with a coffee mug in his left hand. Staff #6 also identified the second resident, in the wheelchair, as being Resident #1. Both residents were moving towards each other in front of the coffee station when Resident #3 was seen waving away Resident #1. Staff #6 shared that it appeared both residents exchanged words (the video had no audio) when Resident #3 was observed tipping over his coffee onto Resident #1's lap. Resident #1 then punched Resident #3 in his left hip. Staff #6 then shared that Staff #81 was now seen on the video walking towards both residents attempting to talk to Resident #3 but Resident #3 continues to fill up his coffee mug and then walked away.</p> <p>An interview was attempted with Social Services Supervisor (SS/Staff #30) on December 26, 2024 at 3:09 P. M, however, staff #30 was out on leave. The current Social Services (SS/Staff #81) indicated that she did not have any information on the incident because Staff #30 was involved in the situation.</p> <p>An interview was conducted with Registered Nurse (RN/Staff ## 81) on December 27, 2024 at 8:29 A.M. Staff #81 described the incident with Resident #3 and Resident #1 as Resident #3 was calling Resident #1 a faggot and took the coffee and poured it. She said that Resident #1 had asked Resident #3 why he had done that to him and Resident #3 just ignored Resident #1 and walked to his chair. Staff #81 shared that Resident #1 had told her that he didn't feel safe with Resident #3. She also shared that after the incident, Resident #3 was not permitted to come out of his room for meals unless he had 1:1 staff with him.</p> <p>An interview was conducted on December 27, 2024 at 8:51 A.M. with Certified Nursing Assistant (CNA/Staff #16). Staff #16 described Resident #3 as a person who likes to assert authority over people and tends to be controlling. He explained that Resident #1 had expressed feeling unsafe from Resident #3 in the past as he would bully Resident #1 and singled him out. Some examples of this behavior were Resident #3 would complain about the (service branch) hat that Resident #1 would wear or he would tell him to get out of here we don't want you here. Staff #16 shared that this had been going on for several months and he would report it to the nurse and the social worker but he was told that the situation was handled. However, he indicated that there was no change in how they were supposed to do their jobs with Resident #3 so he felt that nothing was being done.</p> <p>An interview was conducted on December 27, 2024 at 9:12 A.M. with CNA/Staff # 77. Staff #77 confirmed that she was familiar with Resident #3 as she had worked with him. Staff #77 explained that if Resident #3 did not like you, he was vocal about it and you knew that he didn't like you. Staff #77 shared that Resident #3 did not like Resident #1 so much that if Resident #1 coughed, it would bother Resident #3. Staff #77 shared that she would have to remind Resident #3 that everyone has their own struggles and he didn't understand that. Staff #77 described Resident #1 as innocent and not malicious in anything that he does.</p> <p>(continued on next page)</p>		

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