

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  09/20/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51159</p> <p>Based on clinical record review, staff interview, policy review, and facility documents review, the facility failed to ensure appropriate code statutes per resident request. The deficit practice could result in residents' wishes not being followed.</p> <p>Resident #8 was admitted on [DATE] with diagnosis of epilepsy, hallucinations, sequelae of cerebral infarction, and Parkinson's disease.</p> <p>Care plan for resident #8 revealed that advanced directives will quarterly be communicated and confirmed. Physician's order on resident advance directives will be followed.</p> <p>Progress notes for resident #8 revealed that communication is difficult because of their health condition stated by resident #8 spouse. Assessment was done to identify resident cognition and had revealed resident #8 has a BIMs score of 6. Code statuses on progress notes revealed that resident #8 code status DNR ( Do Not Resuscitate). There are language communication barriers between resident #8 spouse when communicating to staff. Resident #8 spouse was the Power of Authority.</p> <p>Order revealed that there is a discrepancy between orders from physician on resident #8 advance directive, and resident code statutes on the face sheet. An order from physician revealed that resident #8 is full code. Face sheet for resident revealed that resident #8 is DNR.</p> <p>An interview was done with staff #418 practical nurses on September 16, 2024 at 12:21 pm. This staff had stated w reviewing resident code statues, staff will look at the face sheet and click on the advanced directive tab. If code status is not matching with orders, and face sheet they would contact the doctor or family on how they would like to be processed with code statues. The person who is responsible for putting in the code status is the nurse. There is a conflict with resident #8 code status. There needs to be clarity on code status. The risk to code statues not matching would be that we would be going against resident rights and what the resident would want.</p> <p>An interview was done with staff #424 Admission Coordinator on September 17, 2024 on 8:04am. This staff had stated t nurses put resident code status into the system. The Admission Coordinator would put a band on resident wrist to identify if residents are DNR or full code. If residents are full code there would be a white armband on their wrist. If resident code status is DNR there would be a red armband. There is a risk when code statues do not match on orders, and full sheets. This would mean that we can not properly fulfill the full services for the resident.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was done with staff #440 Nurse supervisor on September 17, 2024 at 8:52am. This staff stated when residents are admitted the resident is asked what their wishes are in regards to Advanced Directive. Residents would fill out advance directive and medical treatment decisions form. Residents with low BIMS scores would have a power of attorney or social services would sign off on these forms. Staff #440 Nurse supervisor was the one who admitted resident #8, and had done some of the documentation of admission within the last 30 mins of shifts. Staff #440 Nurse Supervisor had handed everything off to the night shift staff. Night shift typically would do observation. Staff #440 Nurse Supervisor doesn't believe that night shift nurse working with resident #8 followed advanced directive documentations before putting in a code status of do not resuscitate. There was a miscommunication between this night staff nurse and staff #440 Nurse Supervisor. The risk of this event could lead to things to go wrong when treating this resident.</p> <p>An interview was done with staff #410 DON Director of nursing on September 17, 2024 at 12:59am. Staff # 410 stated when residents get to the facility advanced directives are completed by staff. All staff will work with residents to determine if they would like to be in full code or DNR. If a resident is not able to sign then the power of attorney will sign. Code status put in for resident #8 is DNR. Orders for resident #8 advanced directives are Full code. This is a discrepancy with resident #8 advanced directive. The risk of this would be that we are not abiding by the resident wishes. This will be devastating to the family. If we leave the DNR we would let natural death occur.</p> <p>Review of the facility policy titled Advanced Directives any changes on advanced directives will be notified to the physician so that the appropriate documentation of resident advance directives for their orders can be accurately recorded on their medical records.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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**</b> 50166</p> <p>Based on video footage, clinical record review, resident and staff interviews, and policy review, the facility failed to ensure one resident (#35) was not abused by another resident (#43). The deficient practice could result in residents being physically and emotionally harmed.</p> <p>Findings include:</p> <p>Video footage of a resident to resident altercation between residents #35 and #43 was reviewed on September 17, 2024 at 9:08 a.m. with the Assistant Director (AD/Staff#417) and revealed the incident occurred at 6:18 p.m. on May 19, 2024, and physical contact was made between residents #43 and #35.</p> <p>-Regarding Resident #35:</p> <p>Resident #35 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia, post-traumatic stress disorder, essential hypertension, atherosclerotic heart disease, and nicotine dependence. Resident #35 was readmitted to the facility on [DATE].</p> <p>The OBRA Quarterly review Minimum Data Set (MDS) assessment from June 25, 2024 revealed that the resident's Brief Interview for Mental Status (BIMS) score was 15, which indicated intact cognitive impairment. The assessment also revealed that the resident was not exhibiting any behavioral symptoms including physical, verbal, and behaviors not directed towards others, and Resident #35 utilized a wheelchair for mobility.</p> <p>The care plan initiated on September 27, 2023 revealed that Resident #35 was care planned for signs and symptoms of distress related to or not related to mental illness, and assessing for mood, cognition, and behavioral changes.</p> <p>A late entry progress note for Resident #35 from May 19, 2024 at 6:36 p.m. was entered on May 21, 2024 at 5:48 a.m., and documented an altercation between Resident ' s #35 and #43 that was reported to an LPN (LPN/Staff#444) while she passed medications. Resident #35 reported to the LPN that he and Resident #43 had gotten into it. The progress note documented that Resident #43 stated fuck off to Resident #35 who replied you fuck off, and it was also documented in the same note that Resident #43 made frequent attempts to enter Resident #35 ' s room.</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 - Some</p>	<p>A progress note for Resident #35 was entered on May 20, 2024 at 7 a.m. and documented that Resident #35 notified the LPN (LPN/Staff#444) that he had gotten some scratches to his left arm as a result of another resident scratching him. The progress note revealed that the LPN (LPN/Staff#444) notified the Registered Nurse Supervisor (RN/Staff#415), who then went to speak with Resident #35. Resident #35 informed the nurse (RN/Staff#415) that when he was wheeling himself back into the building from smoking outside, Resident #43 was sitting by the door in his wheelchair and asked Resident #35 if he knew where his wife was. Resident #35 replied that he did not know where Resident #43 's wife was and proceeded to try and wheel himself back to his room when Resident #43 grabbed Resident #35 's arm and dug his fingernails into his left arm causing two scratches. Resident #35 attempted to leave but Resident #43 grabbed Resident #35 's wheelchair, preventing him from leaving. The progress note documented that resident #35 asked Resident #43 to let go of his wheelchair but Resident #43 told him that he would hit Resident #35 so hard he would go flying outside. The progress note also documented the resident again reporting the verbal altercation that took place during dinner on May 19, 2024. It was documented in the progress note that on the morning of May 20, 2024, a CNA stated she witnessed Resident #43 flip Resident #35 off when Resident #35 was returning from smoking outside, and at that time the Director of Nursing (DON/Staff#410), Former Assistant Director of Nursing (ADON/Staff#700), and Medical Provider (Dr/Staff#701) were notified.</p> <p>A progress note for Resident #35 on May 21, 2024 at 4:22 p.m. revealed Resident #35 's pain in the left arm was rated a 3/10.</p> <p>Review of the care plan initiated on September 27, 2023 revealed that on May 20, 2024, Resident #35 was documented as an alleged victim of verbal and physical abuse from another resident, and goals were made for him to feel safe from verbal, emotional, and physical abuse by assessing his mood and keeping resident #35 at a distance from Resident #43.</p> <p>Review of Resident #35 's vitals for May of 2024 revealed increased blood pressure in the days following the verbal and physical altercation with Resident #43.</p> <p>Review of Resident #35 's orders revealed he was ordered to be monitored for scratches to his left forearm until healed starting on May 20, 2024 until June 2, 2024.</p> <p>Review of the clinical records for Resident #35 revealed that a skin assessment was not conducted or documented by the facility following the verbal and physical altercation with Resident #43.</p> <p>-Regarding Resident #43:</p> <p>Resident #43 was initially admitted to the facility on [DATE] with diagnoses that included psychotic disorder with hallucinations, unspecified dementia with mood disturbance, hallucinations, depression, essential hypertension, alcohol use, and nicotine dependence. Resident #35 was readmitted to the facility on [DATE].</p> <p>The OBRA Quarterly review Minimum Data Set (MDS) assessment from March 21, 2024 revealed that Resident #43 's Brief Interview for Mental Status (BIMS) score was 15, which indicated intact cognitive impairment. The assessment also revealed that the resident was not exhibiting any behavioral symptoms including physical, verbal, and behaviors not directed towards others, and Resident #43 utilized a manual wheelchair for mobility. It was also documented that Resident #43 did not have hallucinations.</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 - Some</p>	<p>The OBRA Quarterly review Minimum Data Set (MDS) assessment from June 19, 2024 revealed that Resident #43 ' s Brief Interview for Mental Status (BIMS) score was 99. Physical and verbal behaviors were documented as not exhibited, and hallucinations were not present.</p> <p>The care plan initiated on March 15, 2024 revealed that on May 20, 2024 Resident #43 was care planned for socially inappropriate and disruptive behavioral symptoms as evidenced by verbal and physical altercations with Resident #35. Goals were made for Resident #43 to not harm himself or others by allowing distance in seating from Resident #35 and removing resident from group activities when behavior is unacceptable, move resident to a quiet, calm environment. The care plan documented a pattern of verbally and physically aggressive behaviors, and a 1:1 PRN was provided.</p> <p>A progress note for Resident #43 was entered by the RN supervisor (RN/Staff#415) on May 20, 2024 at 7:30 a.m. that documented that residents #43 and #35 got into a physical and verbal altercation in which Resident #43 grabbed his arm and dug his fingernails into his left forearm while trying to return from the outside smoking area back into the building.</p> <p>Review of the reportable event record from May 23, 2024 revealed a statement made by the Assistant Director (AD/Staff#417) who stated As the administrator, I am responsible for abuse reporting and investigation protocols and It does not appear (resident #43) grabbed at (resident #35) left arm or scratched him especially considering they were facing opposite directions. Staff #417 also stated that Resident #35 broke away without significant effort or physical contact.</p> <p>Review of the reportable event record revealed a statement from Resident #35 on May 20, 2024 who stated I did notify the LPN last night of what had happened and was told he was confused.</p> <p>Review of the reportable event record revealed documentation from an interview conducted by the director of nursing (DON/Staff#410) with Resident #35 on May 20, 2024 who stated that he did not feel safe right now and last night. The director of nursing (DON/Staff#410) also stated an undocumented skin assessment was conducted that revealed she examined his arms and saw older scratches, but nothing fresh.</p> <p>An interview was conducted with Resident #35 on September 16, 2024 at 11:49 a.m. who stated Resident #43 sneak attacked him, and he had not had prior issues with Resident #43. Resident #35 stated that he reported the altercation to staff within five minutes of it happening, and he recalled going right to the nurses station after the incident occurred. Resident #35 stated that the police came to speak with him the following day, and he suffered a physical injury that involved bleeding, bruising, and fingernail marks. Resident #35 stated that the nurses cleaned his arm and they did not bandage him up.</p> <p>An interview with the Registered Nurse Supervisor (RN/staff #415) was conducted on September 16, 2024 at 12:40 p.m. who stated that the event on May 19, 2024 between resident #35 and #43 was reported to her directly by Resident #35. Staff #415 stated I reported it to the Administrator and Director of Nursing and she let the administrator know in the morning when Resident #35 told her. Staff #415 stated that Resident #35 reported skin tears where Resident #43 grabbed his arm, and she stated that they did some treatments, cleansed the area, and put bandaids on the injury until it was healed.</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 - Some</p>	<p>An interview with the Assistant Director (AD/Staff#417) was conducted on September 17, 2024 at 9:08 a.m. who stated that he had missed calls at 7 a.m. from the registered nurse and he talked to the Director of Nursing (DON/Staff#410) on May 20, 2024 at 8:20 a.m Staff #417 stated that abuse reporting procedures began at 8:20 a.m. and a report was made to the Arizona Department of Health Services at 10:19 a.m. on May 20, 2024. Staff #417 stated that the first interview of the facility investigation was conducted at 10:30 a. m., and it was the facility ' s expectation that allegations of abuse were reported to the state agency within two hours if there is harm, 24 hours otherwise. Staff #417 also stated that the DON had to gather details to determine if the incident was reportable or not. Staff #417 stated that Resident #35 had a scratch and the facility conducted a skin audit of sorts, but they were unable to produce documentation of a skin audit or shower sheets for May of 2024. Staff #417 stated that the impact of the facility not following abuse policies and procedures was continued abuse, noncompliance, criminal aspects, risk to physical and mental wellbeing, and legal and regulatory implications.</p> <p>51006</p> <p>Based on clinical record reviews, facility documentation, staff interviews, and policy review the facility failed to ensure that two residents (#29 &amp; #259) were free from resident to resident verbal abuse. The deficient practice could result in further resident to resident verbal abuse.</p> <p>In regards to resident #29, findings include:</p> <p>Resident #29 was admitted on [DATE] with the diagnoses of Atherosclerotic heart disease of native coronary artery without angina pectoris; Essential (primary) hypertension; Occlusion and stenosis of unspecified carotid artery; Contact with and (suspected) exposure to other hazardous substances; Gastro-esophageal reflux disease without esophagitis; Other idiopathic peripheral autonomic neuropathy; Peripheral vascular disease, unspecified; Solitary pulmonary nodule; Hyperlipidemia, unspecified; Gout, unspecified; Aneurysm of unspecified site; Alcohol abuse with intoxication, unspecified; and, Occlusion and stenosis of unspecified carotid artery.</p> <p>A review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition.</p> <p>A review of an event note created by Staff #448 on May 13, 2024 at 6:13PM revealed Resident #29's involvement in the incident, indicating that the incident occurred.</p> <p>A review of the intake information for AZ00210421 revealed that the Facility Reported Incident (FRI) was submitted by an Administrator (Staff # 417) on May 14th, 2024 at 4:58PM.</p> <p>A review of intake and 5-day report provided by the facility with a received date of May 16, 2024. The 5-day report revealed that the incident escalated quickly and that both Resident #29 and #259 exchanged profane verbal language to each other. The 5-day report stated that Resident #29 had threatened Resident #259, stating I'm going to get you.</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 - Some</p>	<p>An interview was conducted on September 16, 2024 at 2:03PM with a Licensed Nurse Practitioner (LPN/Staff #448), who stated that Resident #29 was sitting on the left side of the common/dining area, and Resident #259 was seated near the middle of the common/dining area. Staff #448 reported that resident #259 was dependent on staff assistance. Staff #448 reported that Resident #259 had requested staff assistance, and then, Resident #29 had answered for the staff. Staff #448 stated that they were able to de-escalate the altercation. Staff #448 reported that their next steps for the altercation was to go to management to report the incident. Staff #448 reported that the interventions implemented were to keep resident #29 and #259 separate as much as possible, Staff #448 reported that following the incident, Resident # 259 ate their meals in their room. Staff #448 stated that Resident # 259 presented confused and that their diagnosis contributed to their confusion, stating that Resident #259 was out of it.</p> <p>An interview was conducted on September 16, 2024 at 2:23PM with a Certified Nursing Assistant (CNA/Staff #427), who stated that Resident #29 was sitting on the left side of the common/dining area, and Resident #259 was seated near the middle of the common/dining area. Staff #427 reported that resident #259 attempted to get Staff #427's attention and that Resident #29 and #259 started to exchange bad words to each other; then stated that Resident #259 had they're back facing the common/dining area and that he couldn't have known who was talking to him. Staff #427 reported that the intervention that followed the incident was to keep the resident's separated, reported that they're was an incident where Resident #29 required additional staff support to keep him out of Resident #259's room. Staff #427 stated their next intervention was to close Resident #259's door. Indicating that Resident #259's door maintained closed to keep the resident's separated.</p> <p>An interview was conducted on September 17, 2024 at 10:45am with a Registered Nurse (RN/Staff # 410), who stated the expectations and their understanding of the facilities abuse policy. Staff #410 identified abuse as, resident to resident, staff to resident, any form of physical, verbal, maybe stole something, any type of those allegations and altercations. Staff #410 then stated that the impact of abuse on the residents could include, isolation, depression, fear-fear of saying something. Trickle into other symptoms like not eating, not sleeping, fear from being with other residents. Staff #410 then stated her recollection of the incident, that she was notified of the incident, and that both Resident #29 and Resident #259 were both at fault and that the incident would fall as an incident of abuse within their facilities policy.</p> <p>In regards to resident #259, findings include:</p> <p>Resident #259 was admitted on [DATE] with the diagnoses of Hypothyroidism, unspecified; Type 2 diabetes mellitus with diabetic chronic kidney disease; Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Anxiety disorder, unspecified; Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease; Chronic kidney disease, stage 3 unspecified; Adjustment disorder with mixed anxiety and depressed mood; Pressure ulcer of unspecified heel, stage 2 (History of); Pressure ulcer of right heel, stage 3; Pressure ulcer of unspecified heel, stage 2. Resident #259 was discharged on [DATE] by expiration.</p> <p>Review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated severely impaired cognition.</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 - Some</p>	<p>A review of an event note created by Staff #448 on May 13, 2024 @ 6:13PM revealed Resident #29's involvement in the incident, indicating that the incident occurred.</p> <p>A review of the intake information for AZ00210421 revealed that the Facility Reported Incident (FRI) was submitted by an Administrator (Staff # 417) on May 14th, 2024 at 4:58PM.</p> <p>A review of intake and 5-day report provided by the facility with a received date of May 16, 2024 at. The 5-day report revealed that the incident escalated quickly and that both Resident #29 and #259 exchanged profane verbal language to each other. The 5-day report stated that Resident #29 had threatened Resident #259, stating I'm going to get you.</p> <p>An interview was conducted on September 16, 2024 at 2:03PM with a Licensed Nurse Practitioner (LPN/Staff #448), who stated that Resident #29 was sitting on the left side of the common/dining area, and Resident #259 was seated near the middle of the common/dining area. Staff #448 reported that resident #259 was dependent on staff assistance. Staff #448 reported that Resident #259 had requested staff assistance, and then, Resident #29 had answered for the staff. Staff #448 stated that they were able to de-escalate the altercation. Staff #448 reported that their next steps for the altercation was to go to management to report the incident. Staff #448 reported that the interventions implemented were to keep resident #29 and #259 separate as much as possible, Staff #448 reported that following the incident, Resident # 259 ate their meals in their room. Staff #448 stated that Resident # 259 presented confused and that their diagnosis contributed to their confusion, stating that Resident #259 was out of it.</p> <p>An interview was conducted on September 16, 2024 at 2:23PM with a Certified Nursing Assistant (CNA/Staff #427), who stated that Resident #29 was sitting on the left side of the common/dining area, and Resident #259 was seated near the middle of the common/dining area. Staff #427 reported that resident #259 attempted to get Staff #427's attention and that Resident #29 and #259 started to exchange bad words to each other; then stated that Resident #259 had they're back facing the common/dining area and that he couldn't have known who was talking to him. Staff #427 reported that the intervention that followed the incident was to keep the resident's separated, reported that there was an incident where Resident #29 required additional staff support to keep him out of Resident #259's room. Staff #427 stated their next intervention was to close Resident #259's door. Indicating that Resident #259's door maintained closed to keep the resident's separated.</p> <p>An interview was conducted on September 17, 2024 at 10:45am with a Registered Nurse (RN/Staff # 410), who stated the expectations and their understanding of the facilities abuse policy. Staff #410 identified abuse as, resident to resident, staff to resident, any form of physical, verbal, maybe stole something, any type of those allegations and altercations. Staff #410 then stated that the impact of abuse on the residents could include, isolation, depression, fear-fear of saying something. Trickle into other symptoms like not eating, not sleeping, fear from being with other residents. Staff #410 then stated her recollection of the incident, that she was notified of the incident, and that both Resident #29 and Resident #259 were both at fault and that the incident would fall as an incident of abuse within their facilities policy.</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 - Some</p>	<p>A review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation Reporting and Investigating revealed that all reports of resident abuse (including injuries of unknown origin) should be reported to local, state and federal agencies and thoroughly investigated by facility management. The policy revealed that if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law, and Immediately was defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>A review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revealed that the facility should have developed and implemented policies and protocols to prevent and identify abuse or mistreatment of residents, and investigate and report any allegations within timeframes required by federal requirements.</p> <p>A review of facility policy titled Resident Rights revealed that federal and state laws guarantee certain basic rights to all residents of the facility, and those rights included the resident ' s right to be free from abuse, neglect, misappropriation of property, and exploitation.</p>		

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NAME OF PROVIDER OR SUPPLIER  Arizona State Veteran Home - Yuma		STREET ADDRESS, CITY, STATE, ZIP CODE  6051 East 34th Street Yuma, AZ 85365	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50166</p> <p>Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to implement their abuse policy by failing to report an allegation of abuse within the required time for Resident #35. The deficient practice could result in further incidents of abuse not being reported in a timely manner and continued abuse.</p> <p>Findings include:</p> <p>Resident #35 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia, post-traumatic stress disorder, essential hypertension, atherosclerotic heart disease, and nicotine dependence. Resident #35 was readmitted to the facility on [DATE].</p> <p>The OBRA Quarterly review Minimum Data Set (MDS) assessment from June 25, 2024 revealed that the resident's Brief Interview for Mental Status (BIMS) score was 15, which indicated intact cognitive impairment. The assessment also revealed that the resident was not exhibiting any behavioral symptoms including physical, verbal, and behaviors not directed towards others, and Resident #35 utilized a wheelchair for mobility.</p> <p>Resident #43 was initially admitted to the facility on [DATE] with diagnoses that included psychotic disorder with hallucinations, unspecified dementia with mood disturbance, hallucinations, depression, essential hypertension, alcohol use, and nicotine dependence. Resident #35 was readmitted to the facility on [DATE].</p> <p>The OBRA Quarterly review Minimum Data Set (MDS) assessment from March 21, 2024 revealed that Resident #43 ' s Brief Interview for Mental Status (BIMS) score was 15, which indicated intact cognitive impairment. The assessment also revealed that the resident was not exhibiting any behavioral symptoms including physical, verbal, and behaviors not directed towards others, and Resident #43 utilized a manual wheelchair for mobility. It was also documented that Resident #43 did not have hallucinations.</p> <p>The OBRA Quarterly review Minimum Data Set (MDS) assessment from June 19, 2024 revealed that Resident #43 ' s Brief Interview for Mental Status (BIMS) score was 99. Physical and verbal behaviors were documented as not exhibited, and hallucinations were not present.</p> <p>A late entry progress note from May 19, 2024 at 6:36 p.m. was entered on May 21, 2024 at 5:48 a.m., and documented an altercation between Resident ' s #35 and #43 that was reported to an LPN (LPN/Staff#444) while she passed medications. Resident #35 reported to the LPN that he and Resident #43 had gotten into it. The progress note documented that Resident #43 stated fuck off to Resident #35 who replied you fuck off, and it was also documented in the same note that Resident #43 made frequent attempts to enter Resident #35 ' s room.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress note was entered on May 20, 2024 at 7 a.m. and documented that Resident #35 notified the LPN (LPN/Staff#444) that he had gotten some scratches to his left arm as a result of another resident scratching him. The progress note revealed that the LPN (LPN/Staff#444) notified the nurse (RN/Staff#415), who then went to speak with Resident #35. Resident #35 informed the nurse (RN/Staff#415) that when he was wheeling himself back into the building from smoking outside, Resident #43 was sitting by the door in his wheelchair and asked Resident #35 if he knew where his wife was. Resident #35 replied that he did not know where Resident #43 's wife was and proceeded to try and wheel himself back to his room when Resident #43 grabbed Resident #35 's arm and dug his fingernails into his left arm causing two scratches. Resident #35 attempted to leave but Resident #43 grabbed Resident #35 's wheelchair, preventing him from leaving. The progress note documented that resident #35 asked Resident #43 to let go of his wheelchair but Resident #43 told him that he would hit Resident #35 so hard he would go flying outside. The progress note also documented the resident again reporting the verbal altercation that took place during dinner on May 19, 2024. It was documented in the same progress note that on the morning of May 20, 2024, a CNA stated she witnessed Resident #43 flip Resident #35 off when Resident #35 was returning from smoking outside, and at that time the Director of Nursing (DON/Staff#410), Former Assistant Director of Nursing (ADON/Staff#700), and Medical Provider (Dr/Staff#701) were notified.</p> <p>Video footage of the incident was reviewed on September 17, 2024 at 9:08 a.m. with the Assistant Director (AD/Staff#417) and revealed the incident occurred at 6:18 p.m. on May 19, 2024, and physical contact was made between residents #43 and #35.</p> <p>An interview with the Registered Nurse Supervisor (RN/staff #415) was conducted on September 16, 2024 at 12:40 p.m. who stated that the event on May 19, 2024 between resident #35 and #43 was reported to her directly by Resident #35. Staff #415 stated I reported it to the Administrator and Director of Nursing and she let the administrator know in the morning when Resident #35 told her. Staff #415 stated that Resident #35 reported skin tears where Resident #43 grabbed his arm, and she stated that they did some treatments, cleansed the area, and put bandaids on the injury until it was healed.</p> <p>An interview with the Assistant Director (AD/Staff#417) was conducted on September 17, 2024 at 9:08 a.m. who stated that he had missed calls at 7 a.m. from the registered nurse and he talked to the Director of Nursing (DON/Staff#410) on May 20, 2024 at 8:20 a.m Staff #417 stated that abuse reporting procedures began at 8:20 a.m. and a report was made to the Arizona Department of Health Services at 10:19 a.m. on May 20, 2024. Staff #417 stated that the first interview of the facility investigation was conducted at 10:30 a. m., and it was the facility 's expectation that allegations of abuse were reported to the state agency within two hours if there is harm, 24 hours otherwise. Staff #417 also stated that the DON had to gather details to determine if the incident was reportable or not. Staff #417 stated that Resident #35 had a scratch and the facility conducted a skin audit of sorts, but they were unable to produce documentation of a skin audit or shower sheets for May of 2024. Staff #417 stated that the impact of the facility not following abuse policies and procedures was continued abuse, noncompliance, criminal aspects, risk to physical and mental wellbeing, and legal and regulatory implications.</p> <p>51006</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on clinical record reviews, facility documentation, staff interviews, policy review, and the State Operations Manual (SOM), the facility failed to ensure that the policies and procedures to prevent abuse are implemented for two residents (295 &amp; 29). The deficient practice could result in further instances of abuse.</p> <p>Resident #29 was admitted on [DATE] with the diagnoses of Atherosclerotic heart disease of native coronary artery without angina pectoris; Essential (primary) hypertension; Occlusion and stenosis of unspecified carotid artery; Contact with and (suspected) exposure to other hazardous substances; Gastro-esophageal reflux disease without esophagitis; Other idiopathic peripheral autonomic neuropathy; Peripheral vascular disease, unspecified; Solitary pulmonary nodule; Hyperlipidemia, unspecified; Gout, unspecified; Aneurysm of unspecified site; Alcohol abuse with intoxication, unspecified; and, Occlusion and stenosis of unspecified carotid artery.</p> <p>A review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition.</p> <p>A review of an event note created by Staff #448 on May 13, 2024 at 6:13PM revealed Resident #29's involvement in the incident, indicating that the incident occurred.</p> <p>A review of the intake information for AZ00210421 revealed that the Facility Reported Incident (FRI) was submitted by an Administrator (Staff # 417) on May 14th, 2024 at 4:58PM.</p> <p>A review of a late entry progress note completed on May 15,2024 at 6:40PM revealed that on May 13, 2024 at 5:36, a Licensed Master in Social Worker (LMSW/Staff #435) met with Resident #29 after receiving notification of an incident occurring that included verbal threats. Per the late entry progress note, Resident #29 shared what they had experienced during the time of the incident, and, Staff #435 then encouraged Resident #29 to address their concerns with staff and to avoid direct contact with Resident #29.</p> <p>A review of intake and 5-day report provided by the facility with a received date of May 16, 2024. The 5-day report revealed that the incident escalated quickly and that both Resident #29 and #259 exchanged profane verbal language to each other. The 5-day report stated that Resident #29 had threatened Resident #259, stating I'm going to get you. The 5-day report also revealed that the Abuse Coordinator (Staff #417) conducted the investigation following the incident and submitted the FRI. The 5-day report also revealed the scope of the investigation, and the following procedure was listed as followed, a witness statement by a Certified Nursing Assistant (CNA/Staff #427) completed on May 13, 2024, a witness statement by a Licensed Practicing Nurse (LPN/Staff #448 completed on May 13, 2024, an investigation an interview report completed by Social Services (SS) completed on May 13, 2025, and, a late entry psychiatric evaluation submitted on June 9, 2024 at 11:44PM. The 5-day reported also stated the interventions that were utilized following the incident, listed as followed, separate the two residents to keep them away from each other, monitor and report behavioral changes displayed by Resident #259, and that Resident #29 was referred to Alcoholics Anonymous (AA), referred to therapy counseling, and to undergo a medication review.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of late entry psychiatric progress note completed by a Nurse Practitioner (NP/Staff #703) on June 9, 2024 at 11:44PM revealed that Resident #29 met with Staff #703 at 11:44PM on May 31, 2024 to discuss the topics as followed, to engage in social interactions with those he may prefer to socialize with, their recent history of alcohol intoxication, and, as well as, the recent fall prior to the appointment. This psychiatric progress note indicated that there was no indication that the recent verbal resident to resident incident was discussed, and, that there was no review of the medication regime at that time.</p> <p>An interview was conducted on September 16, 2024 at 2:03PM with an LPN (Staff #448), who stated that Resident #29 was sitting on the left side of the common/dining area, and Resident #259 was seated near the middle of the common/dining area. Staff #448 reported that resident #259 was dependent on staff assistance. Staff #448 reported that Resident #259 had requested staff assistance, and then, Resident #29 had answered for the staff. Staff #448 stated that they were able to de-escalate the altercation. Staff #448 reported that their next steps for the altercation was to go to management to report the incident. Staff #448 reported that the interventions implemented were to keep resident #29 and #259 separate as much as possible, Staff #448 reported that following the incident, Resident # 259 ate their meals in their room. Staff #448 stated that Resident # 259 presented confused and that their diagnosis contributed to their confusion, stating that Resident #259 was out of it.</p> <p>An interview was conducted on September 16, 2024 at 2:23PM with a CNA (Staff #427), who stated that Resident #29 was sitting on the left side of the common/dining area, and Resident #259 was seated near the middle of the common/dining area. Staff #427 reported that resident #259 attempted to get Staff #427's attention and that Resident #29 and #259 started to exchange bad words to each other; then stated that Resident #259 had they're back facing the common/dining area and that he couldn't have known who was talking to him. Staff #427 reported that the intervention that followed the incident was to keep the resident's separated, reported that there was an incident where Resident #29 required additional staff support to keep him out of Resident #259's room. Staff #427 stated their next intervention was to close Resident #259's door. Indicating that Resident #259's door maintained closed to keep the resident's separated. Staff #427 stated that Resident #29 and Resident #259 were located on the same unit prior to the incident and after the incident (room [ROOM NUMBER] and #213). This interview indicates that the Resident #29 and Resident #259 were not separated, and the separating intervention was to close the door of Resident #259.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on September 17, 2024 at 10:45am with a Registered Nurse (RN/Staff # 410), who stated the expectations and their understanding of the facilities abuse policy. Staff #410 identified abuse as, resident to resident, staff to resident, any form of physical, verbal, maybe stole something, any type of those allegations and altercations. Staff #410 then stated that the impact of abuse on the residents could include, isolation, depression, fear-fear of saying something. Trickle into other symptoms like not eating, not sleeping, fear from being with other residents. Staff #410 then stated her recollection of the incident, that she was notified of the incident, and that both Resident #29 and Resident #259 were both at fault and that the incident would fall as an incident of abuse within their facilities policy. Staff #410 stated that other implemented interventions included knowledge to be provided to staff to ensure they don't sit next to each other and seen together, a medication review for both Resident #29 and Resident #259. Staff #410 stated that Resident #29 had an update to their treatment plan to monitor behaviors following the incident. Staff #410 stated that Resident #29 was to receive 1:1 therapy session and a psychiatric evaluation. Staff #410 reported that they are not the individual that completes the submission of facility reported incidents, and stated that the remark, I'm going to get you, said by Resident #29 in the 5-day report, can be identified as verbal abuse.</p> <p>An interview was conducted on September 17, 2024 at 11:20AM with an Administrator (Staff # 417), who stated their involvement in the incident as the facility's 'Abuse Coordinator'. Staff #417 stated that their role as an Abuse Coordinator is to determine immediately what the allegation is and if it met the criteria of Abuse. Staff #417 stated that a report will be made within 2 hours if there is harm, otherwise within 24 hours. Staff #410 stated that the information attained from an incident is the initial details of the incident, the names involved in the incident, the location of the incident, the timeframe and date of the incident, and the name of any witnesses. Staff #410 stated that all staff received and continues to receive training regarding abuse, and listed abuse as followed, physical, neglect, verbal, emotional, theft, misappropriation, and degradation. Staff #41 then stated that the impact on the residents that has experienced abuse can manifest in many ways, and listed that as follows, psychosocial, physical, and emotional distress. Regarding the resident to resident abuse incident between Resident #29 and Resident #259, Staff #417 stated that Resident #29 had been the instigator in the incident</p> <p>In regards to resident #259, findings include:</p> <p>Resident #259 was admitted on [DATE] with the diagnoses of Hypothyroidism, unspecified; Type 2 diabetes mellitus with diabetic chronic kidney disease; Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Anxiety disorder, unspecified; Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease; Chronic kidney disease, stage 3 unspecified; Adjustment disorder with mixed anxiety and depressed mood; Pressure ulcer of unspecified heel, stage 2 (History of); Pressure ulcer of right heel, stage 3; Pressure ulcer of unspecified heel, stage 2. Resident #259 was discharged on [DATE] by expiration.</p> <p>A review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated severely impaired cognition.</p> <p>A review of an event note created by Staff #448 on May 13, 2024 @ 6:13PM revealed Resident #29's involvement in the incident, indicating that the incident occurred.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the intake information for AZ00210421 revealed that the Facility Reported Incident (FRI) was submitted by an Administrator (Staff # 417) on May 14th, 2024 at 4:58PM.</p> <p>A review of a progress note dated May 16, 2024 at 3:21PM left by a Registered Nurse (RN/Staff #415) revealed that Resident #259's daughter was notified of the verbal resident to resident incident that occurred on May 13, 2024.</p> <p>A review of intake and 5-day report provided by the facility with a received date of May 16, 2024. The 5-day report revealed that the incident escalated quickly and that both Resident #29 and #259 exchanged profane verbal language to each other. The 5-day report stated that Resident #29 had threatened Resident #259, stating I'm going to get you. The 5-day report also revealed that the Abuse Coordinator (Staff #417) conducted the investigation following the incident and submitted the FRI. The 5-day report also revealed the scope of the investigation, and the following procedure was listed as followed, a witness statement by a Certified Nursing Assistant (CNA/Staff #427) completed on May 13, 2024, a witness statement by a Licensed Practicing Nurse (LPN/Staff #448 completed on May 13, 2024, an investigation an interview report completed by Social Services (SS) completed on May 13, 2025, and, a late entry psychiatric evaluation submitted on June 9, 2024 at 11:44PM. The 5-day reported also stated the interventions that were utilized following the incident, listed as followed, separate the two residents to keep them away from each other, monitor and report behavioral changes displayed by Resident #259, and that Resident #29 was referred to Alcoholics Anonymous (AA), referred to therapy counseling, and to undergo a medication review.</p> <p>Further review of Resident #259's progress notes from the dates of April 1, 2024 to June, 16, 2024 revealed no further discussion or psychiatric evaluations regarding the incident.</p> <p>An interview was conducted on September 16, 2024 at 2:03PM with an LPN (Staff #448), who stated that Resident #29 was sitting on the left side of the common/dining area, and Resident #259 was seated near the middle of the common/dining area. Staff #448 reported that resident #259 was dependent on staff assistance. Staff #448 reported that Resident #259 had requested staff assistance, and then, Resident #29 had answered for the staff. Staff #448 stated that they were able to de-escalate the altercation. Staff #448 reported that their next steps for the altercation was to go to management to report the incident. Staff #448 reported that the interventions implemented were to keep resident #29 and #259 separate as much as possible, Staff #448 reported that following the incident, Resident # 259 ate their meals in their room. Staff #448 stated that Resident # 259 presented confused and that their diagnosis contributed to their confusion, stating that Resident #259 was out of it.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on September 16, 2024 at 2:23PM with a CNA (Staff #427), who stated that Resident #29 was sitting on the left side of the common/dining area, and Resident #259 was seated near the middle of the common/dining area. Staff #427 reported that resident #259 attempted to get Staff #427's attention and that Resident #29 and #259 started to exchange bad words to each other; then stated that Resident #259 had they're back facing the common/dining area and that he couldn't have known who was talking to him. Staff #427 reported that the intervention that followed the incident was to keep the resident's separated, reported that there was an incident where Resident #29 required additional staff support to keep him out of Resident #259's room. Staff #427 stated their next intervention was to close Resident #259's door. Indicating that Resident #259's door maintained closed to keep the resident's separated. Staff #427 stated that Resident #29 and Resident #259 were located on the same unit prior to the incident and after the incident (room [ROOM NUMBER] and #213). This interview indicates that the Resident #29 and Resident #259 were not separated, and the separating intervention was to close the door of Resident #259)</p> <p>An interview was conducted on September 17, 2024 at 10:45am with a Registered Nurse (RN/Staff # 410), who stated the expectations and their understanding of the facilities abuse policy. Staff #410 identified abuse as, resident to resident, staff to resident, any form of physical, verbal, maybe stole something, any type of those allegations and altercations. Staff #410 then stated that the impact of abuse on the residents could include, isolation, depression, fear-fear of saying something. Trickle into other symptoms like not eating, not sleeping, fear from being with other residents. Staff #410 then stated her recollection of the incident, that she was notified of the incident, and that both Resident #29 and Resident #259 were both at fault and that the incident would fall as an incident of abuse within their facilities policy. Staff #410 stated that other implemented interventions included knowledge to be provided to staff to ensure they don't sit next to each other and seen together, a medication review for both Resident #29 and Resident #259. Staff #410 stated that Resident #29 had an update to their treatment plan to monitor behaviors following the incident. Staff #410 stated that Resident #29 was to receive 1:1 therapy session and a psychiatric evaluation. Staff #410 reported that they are not the individual that completes the submission of facility reported incidents, and stated that the remark, I'm going to get you, said by Resident #29 in the 5-day report, can be identified as verbal abuse.</p> <p>An interview was conducted on September 17, 2024 at 11:20AM with an Administrator (Staff # 417), who stated their involvement in the incident as the facility's 'Abuse Coordinator'. Staff #417 stated that their role as an Abuse Coordinator is to determine immediately what the allegation is and if it met the criteria of Abuse. Staff #417 stated that a report will be made within 2 hours if there is harm, otherwise within 24 hours. Staff #410 stated that the information attained from an incident is the initial details of the incident, the names involved in the incident, the location of the incident, the timeframe and date of the incident, and the name of any witnesses. Staff #410 stated that all staff received and continues to receive training regarding abuse, and listed abuse as followed, physical, neglect, verbal, emotional, theft, misappropriation, and degradation. Staff #41 then stated that the impact on the residents that has experienced abuse can manifest in many ways, and listed that as follows, psychosocial, physical, and emotional distress. Regarding the resident to resident abuse incident between Resident #29 and Resident #259, Staff #417 stated that Resident #29 had been the instigator in the incident.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>50166</p> <p>Based on resident and staff interviews, a food test tray, facility documents, and policy review, the facility failed to ensure residents consistently received food that was palatable and warm. The deficient practice could result in the potential for residents who disliked a meal to experience nutritional problems or dissatisfaction with their meals.</p> <p>Findings include:</p> <p>Review of the grievances for the last six months was conducted on September 17, 2024 and revealed three documented grievances regarding cold food temperatures, tough meat, and food not looking appetizing.</p> <p>A grievance was filed on April 22, 2024 for issues with lunch being cold and preferences about desserts.</p> <p>A grievance was filed on May 29, 2024 for the food not being or looking good.</p> <p>A grievance was filed on June 4, 2024 for the food being cold and the meat being tough.</p> <p>Review of the resident council meeting notes for the last three months was conducted on September 17, 2024 and revealed two documented complaints regarding the food temperatures, undercooked foods, and meals missing ingredients.</p> <p>Review of resident council minutes from a meeting held on June 25, 2024 at 10:00 a.m. revealed that meals such as soups, pancakes, and bread were still cold, and meals were still missing ingredients.</p> <p>Review of resident council minutes from a meeting held on August 27, 2024 at 10:00 a.m. revealed that food was cooked fully on one side, but the other side was not cooked. It was also documented that the pork was too tough to eat or cut and the vegetables were overcooked and soggy.</p> <p>A lunch test tray was ordered on September 17, 2024 and arrived at the conference room at 12:20 p.m. The test tray consisted of mashed potatoes, meatloaf, steamed vegetables, and a biscuit. The test tray was sampled by the survey team. The mashed potatoes were measured at 124 degrees and were cold. The meatloaf was measured at 128 degrees, flavorless, and slightly warm to taste. The steamed vegetables were measured at 107 degrees and were mushy and cold. The biscuit was measured at 46 degrees. The survey team deemed the food not palatable or appetizing.</p> <p>An interview was conducted on September 15, 2024 at 2:46 p.m. with resident #17 who stated the food temperatures varied and it was sometimes cold.</p> <p>An interview was conducted on September 17, 2024 with the Kitchen Director (Kitchen Director/Staff#702) who stated that cold food could impact the residents by making them upset, and she was particularly concerned with the elderly population not having palatable food to eat. Staff #702 also stated that nobody likes the pork and once it gets to them, it 's dry.</p> <p>(continued on next page)</p>		

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  09/20/2024
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.			
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the policy titled Food and Nutrition Services revealed that each resident should have been provided with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The policy also states that staff would inspect food trays to ensure the food appears palatable and attractive, and it is served at a safe and appetizing temperature.</p> <p>51159</p> <p>An observation was conducted on 09/17/24 at 11:59 AM during food preparation. Staff # 733 Dietary Manager obtained the following temperature for mash potatoes 168 Degrees fahrenheit, steamed vegetables carrots and green bean 202 degrees fahrenheit, gravy 160 degrees fahrenheit, meatloaf 167 degrees fahrenheit, and transitional meatloaf 199 degrees fahrenheit.</p> <p>An observation was conducted during the tray line on 09/17/ 24 12:12 PM. Resident food was passed out in the dining area not too far from the kitchen. Last tray was brought up to surveyors by Staff # 733 Dietary manager.</p> <p>An observation was done with a test tray on 09/17/24 12:21PM. Staff # 733 Dietary Manager obtained the following temperature for mash potatoes 124 degrees fahrenheit, meat loaf 128 degrees fahrenheit, steamed vegetables carrots and green beans 107 degrees fahrenheit. Food test taste had revealed that mashed potatoes were cold.</p> <p>Interview with Staff # 702 Director of kitchen 09/18/24 on 11:44 AM</p> <p>An interview was done the Staff # 702 Director of kitchen on September 18, 024 at 11:44am. This staff stated that two of the units do not have a hot plate. The impact of food not being warm makes residents upset. This is a concern to the elderly population.</p> <p>Review of the policy titled Food and Nutrition Services revealed that each resident should have been provided with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The policy also states that staff would inspect food trays to ensure the food appears palatable and attractive, and it is served at a safe and appetizing temperature.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51159</p> <p>Based on observations, staff interview, and policy review, the facility failed to ensure safety and sanitary kitchen regarding expired items, dusty dishwasher, and rotten produce, and food labeling. The deficient practice in this will lead to food contamination.</p> <p>During an observation on [DATE] at 11:24 am on the walk-in cooler, multiple iceberg lettuce items had brownish spotting, white/gray fuzzy growth spots, and slimy liquid substances. Bell peppers had white/gray fuzzy growth spots, and blackish spots. An apple had a mushy spot on its surface. The pantry had an expired brown sugar label dated back to [DATE].</p> <p>An interview was done with staff #722 a dietary aid on [DATE] who stated that</p> <p>A few days ago they would have tossed those lettuce out. These food items are moldy. They figured that they would have gone to the trash. They would not serve this to anyone. If food items have mold or black spotting they would have been tossed out.</p> <p>An second observation was done on [DATE] at 7:34 am, which revealed that a</p> <p>soap dispenser near dishware sink not properly working. Small fan facing dishware has built up dust and was in use. Food crumbs on top of seven cups that were on the dishware rack. Walk in cooler had two drinks dispersed not properly labeled. This labeling was missing the date when the item was made, name of item, and expiration date. In the pantry was [NAME] spaghetti package that had a ripped exposing the pasta. In the reach in the refrigerator was an expired Teriyaki sauce with an expiration date [DATE].</p> <p>An observation was done on a unit refrigerator named Citrus on [DATE]th, 2024 at 8:03 am. Food items : Philadelphia blueberry cream cheese, [NAME]-Daz mango 14 fl oz, Private Selection black cherry ice cream 1 pt, and ,d+[DATE] peanut butter sandwich were not properly labeled. This labeling did not include: date received, resident name, and expiration date.</p> <p>An interview was done with staff #518 a Certified Nurse Aide on [DATE] at 8:05 am. This staff stated that kitchen staff are the ones who bring in the food into unit refrigerators . Food that comes from outside the facility would be labeled with when it was brought in, expiration date, and who the food items belong to. If food has been in the refrigerator for a long time it would be tossed out. These items in the refrigerator are not properly labeled. This risk can cause an impact.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Arizona State Veteran Home - Yuma		STREET ADDRESS, CITY, STATE, ZIP CODE  6051 East 34th Street Yuma, AZ 85365	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was done with staff #702 the director of Kitchen on [DATE] at 11:44 am. This staff stated the source is delivered Tuesday, and Friday by US Food. It is a requirement to have labeling on food items like for example the received dates. The standards for cleaning kitchen and dishwashing are every day after every shift. If something hits the floor we would clean up right away. After every meal everything gets clean by dietary. We do not have a cleaning log, or a cleaning checklist. Those that are in charge of stocking, and cleaning the unit refrigerator in each unit are dietary aids that do it daily. The expectation for stocking and cleaning out the unit refrigerator for each unit would be to not overfill, labeling for items that belong to the resident. There is a resident consults every month to discuss concerns on food , and likes and dislikes. These fans in the kitchen are blowing dust into the food and should not be here. Our fans are not up to facility standards.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>50166</p> <p>Based on observations, facility documentation, staff interviews, and policy review, the facility failed to ensure that the required staffing information and CASPER Payroll-Based Journal (PBJ) data was submitted to CMS (Centers for Medicare &amp; Medicaid Services) for two quarters. The deficient practice could result in residents receiving inadequate care due to a potential lack of staffing.</p> <p>Findings include:</p> <p>A review of the [NAME] PBJ Staffing Data Report that was run on September 10, 2024 revealed that the facility was triggered for failure to submit data for the quarter for the following:</p> <p>Fiscal year, quarter two (January 1st - March 31st) 2024</p> <p>Fiscal year quarter three (April 1st - June 30th) 2024</p> <p>An interview was conducted on September 17, 2024 at 2:10 p.m. with the Assistant Director (Staff#417) who stated that it was the facility ' s expectation that they submit the PBJ Report quarterly, and it was the job of the Staffing and Payroll Coordinator (Staff/#417) to submit the data. Staff #417 also stated that the facility did not have a Medicare number until April of 2024, which was the reason they did not submit for quarter two (January 1st - March 31st), but he was not sure because it was near the end of the quarter. Staff #417 stated that the facility was aware that they should have submitted for quarter three (April 1st- June 30th), but they did not turn one in and he knew for sure we had to be turning it in. Staff #417 stated that the risk of not submitting the PBJ was that their star rating on staffing would be impacted. He stated that submitting their PBJ data was a requirement because it was a way for them to know they have the right staff in the right categories, and not submitting the PBJ for two quarters was not acceptable.</p>