STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035250	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel Campus of Care	11301 North 99th Avenue Peoria, AZ 85345

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on observation, clinical record review, staff interviews, review of facility documentation and policy, the facility failed to ensure that the skin assessment was complete and accurately documented in the clinical record for one resident (#43). The deficient practice could result in inaccurate information of the condition or status of the resident that could affect the care provided to the resident. Findings include: Resident #43 was admitted on [DATE] with diagnoses of senile degeneration of brain, chronic kidney disease, stage 2, dementia, anxiety, major depressive disorder. A review of the annual MDS (minimum data set) dated June 18, 2024 revealed that the resident had a BIMS (brief interview of mental status) score of 00 indicating the resident had severe cognitive impairment. The care plan with revision date of June 19, 2024 included that the resident was at risk for skin breakdown. Interventions included padding of the left side of the bed rails due to resident reaching through the pull bars to reach the night stand. The weekly skin check dated June 20, 2024 revealed the resident had no skin breakdown, or no open areas or areas of concern. A review of the progress note dated June 25, 2024 revealed that the resident had a discoloration to left forearm, dark blue in color; and a non-visible discoloration to right arm. Per the documentation, the skin was intact and a certified nurse assistant (CNA) noted the discoloration while giving care. Another progress note dated June 25, 2024 included that the resident had a quarter sized brownish discoloration on the left wrist and appeared to be a resolving bruise. Per the documentation, the resident can be fidgety, uncooperative with care, and had poor safety awareness; and that, the resident could have bumped her wrist on pull bar. The note also included that there was no swelling, no pain, and the resident had full ROM in left fingers, elbow, and shoulder. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress note dated June 27, 2024 revealed the resident had four (4) dark discolorations on right inner, upper arm; and that, the areas were not raised and was not painful when palpated. However, the weekly skin check dated June 27, 2024 revealed the resident had no skin breakdown, or no open areas or areas of concern. The documentation did not include the resident had discoloration to the skin. The weekly skin checks dated July 2 and July 4, 2024 continued to include that the resident had no skin breakdown, or no open areas or areas of concern. The documentation did not include the resident had discoloration to the skin. An observation of resident #43 was conducted with a CNA (staff #224) on July 9, 2024 at 9:53 a.m. The resident had yellow and green-colored bruises to the lower right forearm; and, a larger bruise that was green in color near the right elbow. An interview certified nursing assistant (CNA/Staff #224) was conducted on July 9, 2024 at 9:55 a.m. The CNA stated that resident's bed had padded bedrails to prevent the resident from bruising her arms. The CNA also stated that the resident would place her arms in between the bedrails when trying to reach her nightstand or when feeling anxious. In an interview with a licensed practical nurse (LPN/staff #40) conducted on July 9, 2024 at 10:13 a.m. The LPN stated that she was familiar with resident #43; and that, a few weeks prior a night nurse had reported bruising. The LPN stated that the night nurse asked the resident and her roommate what happened because the resident was crying at 3:00 a.m. The LPN said that the resident had complained of her arm hurting; and that, the bruise had turned to a yellowish-green color. She further stated the resident had recently received an abrasion from hitting her arm under the dining table. During the interview, a review of the clinical record was conducted with the LPN who stated that the weekly skin assessments should have noted the bruising on resident #43. The LPN further stated that the weekly skin assessment dated for June 27, 2024 did not document that the resident had bruising to the left and right arm. An interview was conducted with Director of Nursing (DON/staff #83) on July 9, 2024 at 10:25 a.m. The DON stated that skin assessments were completed once a week for every resident; and, were usually completed on the resident's shower days to make it easier for the resident. The DON said that weekly skin assessments should be documented accurately and should include the skin is either intact or any open area, treatment in place, and document any skin tear, pressure ulcer, bruises or any breaks in the skin or alteration in the skin. She further stated this would include new bruises, documentation of prior bruises; and that, anything other than their natural skin should be documented on the skin assessment. Review of the facility policy titled Skin Assessment Frequency Policy states it is our policy to perform full body assessment as part of our systemic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment.