

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/20/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Campus of Care		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40581</p> <p>Based on observation, documentation, resident and staff interviews, and the facility policy and procedures, the facility failed to ensure that residents (#55 and #33) were allowed to leave their rooms during a COVID-19 outbreak. The deficient practice could result in residents not being treated with dignity and respect or afforded their rights.</p> <p>Findings include:</p> <p>Resident #55 was admitted to the facility on [DATE] with diagnoses that included dementia in other diseased classified, traumatic brain injury, adjustment disorder, schizoaffective disorder, and bipolar disorder.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 9 indicating the resident had a moderate cognitive impairment.</p> <p>The COVID-19 line listing documentation revealed that resident #55 tested positive for COVID-19 on December 2, 2024 and was asymptomatic.</p> <p>Note: resident #55 remained quarantined on December 20, 2024, which was a total of 18 days.</p> <p>-Resident #33 was admitted to the facility on [DATE] with diagnoses that included major depression, general anxiety, and borderline personality disorder.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact.</p> <p>The COVID-19 line listing documentation revealed that resident #33 tested positive for COVID-19 on December 2, 2024 and was asymptomatic.</p> <p>Note: resident #33 remained quarantined on December 20, 2024, which was a total of 18 days.</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 0550</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 19, 2024 at 4:15 p.m. with resident #55, who stated that he is not allowed to go out of his room because of COVID-19. He stated that he is not sick and has not been allowed to go for a cigarette. The resident was upset as evidenced by the increased volume and irritated tone of his voice. During the interview, resident #66 called out from across the hall and wanted to report that he was told that he can't come out of his room, but he did have COVID-19. During this time, another resident #33 ambulated in her wheelchair to the door of her room and stated that she is not allowed out of her room and no one answered her call light. Then, a certified nursing assistant (CNA/staff #6) was observed carrying a food tray towards resident #33's room and heard telling resident #33 to get back in her room, your not supposed to be out of your room in an unwelcoming tone. Staff #6 went into resident #33's room to deliver the food tray and resident #33 was heard saying, don't you like me to staff #6 and staff #6 said, don't talk like that, in an unfriendly and gruff voice, and walked out of the resident's room. The surveyor stopped staff #6 and asked for an interview. Staff #6's tone and general demeanor softened and she stated that there is COVID-19 on the unit and this is why residents are not supposed to come out of their rooms and why she is delivering food trays to the residents' rooms.</p> <p>During an interview was conducted on December 20, 2024 at 8:30 a.m. with the Nursing Administrator Staff (LPN/staff 17), staff reviewed the COVID-19 Line List and stated that resident #55 and #33 tested positive for COVID-19 on December 2, 2024, so they should have been able to come out of their room as of December 10, 2024. She stated that residents out of quarantine and residents who are COVID-19 negative should have been allowed to come out of their rooms, eat meals and do activities in the public area. She stated that if staff are telling residents that they can't come out of their rooms, it is a violation of resident rights and seclusion is a form of abuse. She stated that if she heard a staff telling a resident to get back in his or her room, she would consider a dignity and respect issue. She stated that she never told staff the the residents could not come out of their rooms because COVID-19 was spreading.</p> <p>An interview was conducted on December 20, 2024 at 9:16 a.m. with the Quality Assurance and Performance Improvement (QAPI) nurse, who identified herself as the Infection Control Preventionist (staff #20). She stated that after the seven days, she notifies the staff that the resident can come out of his or her room. She reviewed the COVID-19 Line List and stated that resident #55 and #33 tested positive for COVID-19 on December 2, 2024, so they should have been able to come out of their rooms as of December 10, 2024 and meals and activities should have been offered in the dining room. She stated that staff cannot tell residents to get back in their rooms because it is a form of seclusion and is a matter of dignity and respect. She stated that if she witnessed a staff telling a residents to get back in their rooms, she would remove the resident from the unit, re-educate the staff, and write the staff up if this was a pattern of behavior and seclusion if a form of abuse. She stated that she never told staff that the residents had to stay in their rooms, but may have told staff to encourage the residents to stay in their rooms because COVID-19 is spreading. Then, (staff #20) stated that this never applied to all the residents, just the residents who were COVID-19 positive. She also stated that the Nursing Administrator Staff (LPN/staff 17) never assisted her with implementing procedures or monitoring the COVID-19 outbreak.</p> <p>An interview was conducted on December 20, 2024 at 4:35 p.m. with a licensed practical nurse (LPN/staff #14), who stated that she was told by the nursing administrator staff (LPN/staff #17) and the QAPI nurse (LPN/staff #20) that none of the residents are allowed to come out of their rooms because people keep getting sick.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy, Resident Rights states that Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include to be treated with respect, kindness, and dignity, and to be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40581</p> <p>Based on documentation, resident and staff interviews, and the facility policy and procedures, the facility failed to ensure that residents (#55 and #33) were offered activities when they were COVID-19 positive and the residents on their unit were not allowed to attend activities in the common area. The deficient practice could impact the psychosocial well being of residents.</p> <p>Findings include:</p> <p>Resident #55 was admitted to the facility on [DATE] with diagnoses that included dementia in other diseased classified, traumatic brain injury, adjustment disorder, schizoaffective disorder, and bipolar disorder.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 9 indicating the resident had a moderate cognitive impairment.</p> <p>The COVID-19 line listing documentation revealed that resident #55 tested positive for COVID-19 on December 2, 2024 and was asymptomatic.</p> <p>Note: resident #55 remained quarantined on December 20, 2024, which was a total of 18 days.</p> <p>-Resident #33 was admitted to the facility on with diagnoses that included</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact.</p> <p>The COVID-19 line listing documentation revealed that resident #33 tested positive for COVID-19 on December 2, 2024 and was asymptomatic.</p> <p>Note: resident #55 remained quarantined on December 20, 2024, which was a total of 18 days.</p> <p>An interview was conducted on December 19, 2024 at 4:15 p.m. with resident #55, who stated that he is not allowed to go out of his room because of COVID-19. He stated that he is not sick and has not been allowed to go for a cigarette. The resident was upset as evidenced by the increased volume and irritated tone of his voice. During the interview, resident #66 called out from across the hall and wanted to report that he was told that he can't come out of his room, but he did have COVID-19. During this time, another resident #33 ambulated in her wheelchair to the door of her room and stated that she is not allowed out of her room. Then, a certified nursing assistant (CNA/staff #6) was observed carrying a food tray towards resident #33's room and heard telling resident #33 to get back in her room, your not supposed to be out of your room in an unwelcoming tone. Staff #6 went into resident #33's room to deliver the food tray and resident #33 was heard saying, don't you like me to staff #6 and staff #6 said, don't talk like that, in an unfriendly and gruff voice, and walked out of the resident's room. The surveyor stopped staff #6 and asked for an interview. Staff #6's tone and general demeanor softened and she stated that there is COVID-19 on the unit and this is why residents are not supposed to come out of their rooms and why she is delivering food trays to the residents' rooms.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on December 20, 2024 at 8:30 a.m. with the Nursing Administrator Staff (LPN/staff 17), she reviewed the COVID-19 Line List and stated that resident #55 and #33 tested positive for COVID-19 on December 2, 2024, so they should have been able to come out of their rooms as of December 10, 2024. She stated that residents out of quarantine and residents who are COVID-19 negative should have been aloud to come out of their rooms, eat meals and do activities in the public area. She stated that she told the staff that residents are allowed to come out of their rooms to attend activities and staff could encourage residents to wear masks.</p> <p>An interview was conducted on December 20, 2024 at 9:16 a.m. with the the Quality Assurance and Performance Improvement (QAPI) nurse, who identified herself as the Infection Control Preventionist (staff #20). She stated that the quarantine time for COVID-19 is seven days. She stated that after the seven days, she notifies the staff that the resident can come out of his or her room. She reviewed the COVID-19 Line List and stated that resident #55 and #33 tested positive for COVID-19 on December 2, 2024, so they should have been able to come out of their rooms as of December 10, 2024 and meals and activities should have been offered in the dining room.</p> <p>An interview was conducted on December 20, 2024 at 10:05 a.m. with the activity assistant/Life Enrichment Associate (staff #26) and the Life Enrichment Director (staff #35). Staff #26 stated that the purpose of activities is to keep the residents entertained, out of bed, and happy. She stated that each resident is assessed and asked what he or she likes to do and if a resident is not attending activities, she would assume that something is wrong, such as the resident is sad, and would report it to the nurse. Then, she stated that she doesn't document the types of activities or the number of times any resident attends activities, so she guesses that she wouldn't really know if a resident had a change of condition. She stated that during the COVID-19 outbreak, she did not offer any of the residents who were COVID-19 positive any activity materials and did not want to put on the personal protective equipment (PPE) to enter their rooms, but it was her understanding that she was supposed to offer them activity packets. She thought that the quarantine was ten days and stated that she was told by a nurse when the quarantine ended for a resident. She stated that the COVID-19 outbreak made her nervous and she didn't offer any activities to the residents on the unit who tested positive for ten days. She stated that there is a risk of residents not having anything to do and she was not following the activity care plan when she didn't offer activities to the residents. She stated that she had been offering activities to a few of the residents in the dining room. During the interview, (staff #35) stated that the purpose of activities is to improve lives, help with depression, physical and emotional well being, and it creates a sense of community. She stated that she reviews the residents quarterly and when their is a change in condition or concern regarding activity participation, but didn't have any documentation for any of these residents.</p> <p>An interview was conducted on December 20, 2024 at 10:51 a.m. with the Director of Nursing (DON/staff #1), who stated that all residents who were COVID-19 free, were allowed to move around on the unit. She stated that one-to-one activities were offered to the residents who were COVID-19 positive in their rooms and the other residents were allowed to attend regular activities. It was her expectation that activities are documented: attended, not attending, passive and self-directed for each resident. The activity assistant/Life Enrichment Associate (staff #26) should be following the activity care plan for each resident and the purpose of activities is keep the residents engaged, happy, and to decrease behaviors. She stated that the risk of not offering activities is that residents may experience depression, self-isolation, and anxiety sometimes.</p> <p>(continued on next page)</p>		

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<p>F 0679</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 20, 2024 at 4:35 p.m. with a licensed practical nurse (LPN/staff #14), who stated that she was told by the nursing administrator staff (LPN/staff #17) and the QAPI nurse (LPN/staff #20) that none of the residents are allowed to come out of their rooms because people keep getting sick.</p> <p>Review of the facility policy, Resident Rights revealed that employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: communication with and access to people and services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40581</p> <p>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure one resident (#77) was provided the supervision needed to maintain her health and safety. The deficient practice could result in residents being harmed physically and psychologically.</p> <p>Findings included:</p> <p>Resident #77 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included borderline personality disorder, schizoaffective disorder, major depression, and generalized anxiety.</p> <p>The behavior psychiatric evaluation dated September 21, 2024 revealed that the chief complaint was depressed mood and suicidal thoughts. The patient was admitted with depressed mood and suicidal attempt. As per the clinical and multidisciplinary team (MDT) assessment, the patient is functionally impaired due to influence of symptoms and is risky to get discharged from the inpatient unit.</p> <p>The Approach Plan/behavior plan date May 9, 2023 revealed that the resident had a self-harming/suicidal history. Interventions included to be aware of history of self-harm, suicidal ideation and/or prior attempted suicides and ensure the resident knows she is a valued person. If observing an increase in mood or harm is being expressed, contact the psych provider.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview mental status score of 15 indicating the resident was cognitively intact.</p> <p>Review of the care plan dated November 4, 2024 revealed that the resident had a history of suicidal ideations/attempts. Interventions included to see the behavior plan.</p> <p>A behavior note dated December 18, 2024 revealed that the resident was transferred to a unit to be monitored for suicidal safety reason. The resident was to remain on one-to-one supervision care.</p> <p>Review of the 5-day written investigation dated December 20, 2024 revealed that prior to the resident being left unsupervised, one staff had left the unit to assist with an emergency in another area, adding to the strain on staff.</p> <p>A progress note dated December 18, 2024 revealed that at approximately 7:10 p.m. staff went into the resident's room and noted that the resident had a sheet wrapped around her neck. The resident was pink in color and responsive. The sheet was removed from her neck and she was taken to the nurses station. She verbalized that she was depressed and wanted to harm herself. The resident was assessed for injury and vital signs (VS) were taken. VS: 127/104, 155, 99% RA, 98 F, 24. Crisis line was called and advised to call the fire department. The Director of Nursing (DON), Administrator, nurse practitioner (NP), power of attorney (POA), and the assistant director of nursing (ADON) were notified. The emergency medical services (EMS) arrived at approximately 7:30 p.m. and the resident left the facility at approximately 7:40 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0689</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 20, 2024 at 10:51 p.m. with the Director of Nursing (DON/staff #1), who stated that resident #77 was supposed to have a one-to-one staffing ratio because she was having a hard time. She stated that the one-to-one left resident #77 to assist staff with another resident. Resident #77 was found standing on her bed with a sheet wrapped around her neck and 911 was called. She was transferred to the hospital because she stated that she wanted to harm herself. Staff #1 stated that since then, the staff are being retrained not to leave a resident if staff is assigned as the one-to-one even if there is a situation with another resident.</p> <p>An interview was conducted on December 20, 2024 at 2:29 p.m. with a licensed practical nurse (LPN/staff #12), who stated that the resident had just transferred to the unit and was supposed to have a one-to-one staff. The one-to-one was the only male staff on the unit and when another male resident was trying to break through the locked door, the male staff was the only one strong enough to handle him. The male resident was kicking and screaming. When the male staff went to help with the male resident, resident #77 was left unsupervised. Resident #77 went into her room and was found with a sheet wrapped around her neck trying to hang herself from the ceiling. Staff #12 pointed and identified the male resident #99 as the resident who was trying to break down the doors to get out.</p> <p>The facility policy, Safety and Supervision of Residents states that the resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.</p>		