| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035250 | A. Building<br>B. Wing | 03/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Immanuel Campus of Care | 11301 North 99th Avenue<br>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.

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910<br><br>Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that two residents (#1 and #2) were free from physical abuse. The deficient practice could result in further incidents of staff to resident abuse.<br><br>Findings include:<br><br>- Regarding resident#1:<br><br>Resident #1 was admitted to the facility on [DATE] with diagnosis including conduct disorder, unspecified, personal history of traumatic brain injury, unspecified mood [affective] disorder, violent behavior, anxiety disorder, unspecified.<br><br>A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Further review of the MDS revealed no indicators for mood or behaviors and dependent for activities of daily living and substantial/maximal assist for mobility.<br><br>A review of the care plan initiated on November 25, 2024 revealed a focus area indicating that the resident has a psychosocial wellbeing problem related to traumatic brain injury. Interventions included allowing the resident time to answer questions and to verbalize feelings, perceptions and fears. Further review of the care plan revealed a focus area that the resident has a behavior problem related to verbal aggression. Interventions included intervening as to protect the rights and safety of others, approaching and speaking to the resident in a calm manner, diverting their attention, remove from situation and take to alternate location as needed. If reasonable, discuss the resident's behavior and explain or reinforce why the behavior is inappropriate and/or unacceptable to the resident.<br><br>A review of the progress notes for March 9, 2025 revealed no documentation regarding the alleged abuse of staff to resident.<br><br>A review of the Weekly Skin Evaluation dated March 10, 2025 revealed no breakdowns, open areas or areas of concern for resident #1.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An attempt to conduct a telephonic interview was conducted March 20, 2025 at 11:30am with certified nursing assistant (CNA/Staff #5). There was no response. Message left for a return phone call.<br><br>An interview was conducted on conducted on March 20, 2025 at 2:30 p.m. with Licensed Practical Nurse (LPN/Staff #11). Staff #11 stated resident #1 was seated in his wheelchair in the far in of the community room and was trying to go to the side of the room where there were other residents and CNA #5 were seated. Staff #11 stated CNA #5 did not want the resident in the area she was seated at and CNA#5 pushed the resident roughly and resident #1 was resistant. Staff #11 stated he was concerned with what he saw and told CNA #5 to stop and that CNA #5 stated I don't care. Staff #11 stated I told her to be careful pushing resident #1. Staff #11 stated the CNA#5 did not explain to the resident #1 what she was going to do as she pulled the resident back to the far corner of the room. Staff #11 stated he told CNA#5 to keep serving the residents their meals. Staff #11 stated he continued with his med pass believing CNA #5 had listened to his directive. Staff #11 stated he noticed CNA #5 went to the nurse's station and grabbed a desk chair and went towards resident #1 who was propelling himself towards the table she did not want him to sit at, and purposely tipped the desk chair behind resident #1 and aggressively and with force pushed the desk chair against the back of the resident's wheelchair hitting resident #1 on his upper back. Staff #11 stated Staff #5 displayed abusing behavior I told her repeatedly to stay away from the resident due to her anger that was directed towards the resident- the resident had not done anything to her. Staff #11 stated CNA #5 had a temper and had been aggressive with resident #1 before and used to pull him back and she would take the bib and used it to pull the resident back forcefully- jerking the resident. Staff #11 stated he did not report the prior incident because I talked to her about what she did and thought it would not happen again.<br><br>An attempt to interview was conducted on March 20, 2025 at 2:48 pm with resident #1. Due to the resident's cognition and BIMS score of 00, the interview could not be completed. The resident was unable to follow line of questioning or remembrance of the alleged event.<br><br>A review of the facility reportable event report with discover date of March 10, 2025 revealed both resident #1 and Staff #5 were interviewed. Interview with resident #1 was unable to be completed due to level of cognition, but the resident answered yes to fell ing safe in the facility. Staff #5 reported that she felt the need to defend herself by pushing her chair into the resident's wheelchair and could have handled her frustration differently and stopped when told to by the nurse. Staff #5 was immediately suspended and resident #1 was assessed revealing no injuries. Staff #5 was terminated and Stated Board of Nursing notified of the abuse.<br><br>-Regarding Resident #2<br><br>Resident #2 was admitted to the facility on [DATE] with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, recurrent, unspecified, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, mood disorder due to known physiological condition, unspecified.<br><br>Review of the Care Plan initiated on August 17, 2024 revealed and area of focus for physically aggressive behaviors related to depression by spitting at staff. Interventions included staff will observe behavior occurrences, cause, interventions and effect and report as needed. Further review of the care plan revealed a focus for smoking. Interventions included instructing on facility policy regarding smoking times, locations and safety concerns.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. Further review of the MDS revealed no indicators for mood and behavioral symptoms directed towards others.<br><br>Review of the behavior charting dated March 19, 2025 for resident #2 revealed resident was redirected when cussing and name calling to staff and going on nursing station without permission. The charting stated the resident #2. attends supervised smoke break, and able to let needs be known. Further review revealed resident compliant with medication, participated in the last supervised smoke break of the day, no negative behavior and resident is sleeping comfortably through the night.<br><br>Review of the progress notes revealed no documentation regarding alleged staff to resident abuse.<br><br>An interview as conducted on March 20, 2025 at 2:52 pm with resident #2. Resident #2 stated he had come from his shower and wanted to be shaved. Resident #2 stated CNA/Staff#7 told him to go to his room. Resident #2 stated Staff #7 said go to your room like I was a little kid. Resident #2 stated I told her to go f**k herself. Resident #2 stated CNA #7 said f*** you mother****** go to your room mother******. Resident #2 stated it made me feel very mad when she spoke to me in that language. Resident #2 stated he has had no further problems since and that staff #7 has not been back.<br><br>A telephonic interview was conducted on March 20, 2025 at 12:21 pm with CNA/Staff #7. Staff #7 said she was assisting with resident #2. Staff #7 stated she has been employed with the facility since May 2024 and received CPI training as part of the new hire process and had refresher training November 2024. Staff #7 stated resident #2 wanted his head shaved and wanted CNA/Staff#22 to shave his head bald. Staff #7 stated resident #2 had followed her and staff#22 and behind the red line at the nursing station and was yelling and screaming at Staff #22 to have his head shaved. Staff #7 stated Staff #22 explained to him she could not do it at that time due to completing rounds, but that she could do it later. He started swing his arms as if to hit someone, I got around him to pull the resident out of the red line area as he was swinging at staff #22. Staff #7 stated she told the resident that if staff #22 did not have time to shave his head, she would since she was staying until 4:30pm. Staff #7 stated resident #2 started screaming using the Mother***(MF) and B word. Staff #7 stated she explained to the resident he could not use that language. Staff #7 stated additional staff came to assist and tried to calm the resident down. Staff #7 stated Registered Nurse/ Staff # 32 asked that she finish her rounds. Staff #7 denied using inappropriate language directed at the resident, that she just kept telling him to not use the MF or B word. Staff #7 stated that she did tell resident #2 that she would not take him for his smoke break. Staff #7 stated she told the resident this because he was already upset with her, not to punish the resident, but because he was already upset with her. Staff #7 stated I did not tell him correctly.<br><br>An interview was conducted on March 20, 2025 at 12:53 pm with Registered Nurse (RN/ Staff # 32). Staff #32 stated she worked for the facility since 2016 and worked on the unit the date of the alleged incident. Staff #32 stated she is familiar with resident #2 and staff #7. Staff #32 stated resident #2 has a history of being verbally and physically abusive towards staff, attention seeking, and demanding with care. Staff #2 stated she was not present at the actual incident and was told by CNA/Staff #7 that the resident was following another staff member and had crossed the red line. Staff #32 stated staff #7 told her that she and staff #22 were telling resident #2 to go back and he tried to hit one of them, calling them names using the word b****, and m*****f***** and f***y**. Staff #32 stated I am surprised because she is our go-to CNA, a hard worker and very good with the residents.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on March 20, 2025 at 1:12 pm with (CNA/Staff #22). Staff #22 stated she has worked for the facility for [AGE] years and has worked with staff #7. Staff #22 stated she is good with the residents, but has an aggressive tone. I have heard her speaking to the CNA's with who she has a problem or with some of the residents. Staff #22 stated she was assigned resident #2 on the date of the alleged incident. Staff #22 stated he asked me to shave, I told him when lunch is done I will come and find you- he said ok. Staff #22 stated she went to lay down another resident and when she came out of the room she saw staff #7 taking resident #2 to the soiled laundry. Staff #22 stated staff #7 told her she was bringing him to staff#22 to shave. Staff #22 stated she told staff #7 that she had already spoken to him and that she would take care of him after lunch. Staff #22 stated Staff #7 told the resident he would have to wait and started taking him to the dining room. Staff #22 stated when the resident became upset and started using foul language, she walked away. Staff #22 stated staff #7 got mad and came back and said what did you say?. Staff #22 stated staff #7 told resident#2 that you have to respect me and if you keep talking to me that way I'm not taking you to smoke. Staff #22 stated there were other words that were said but she did not hear them, but that she was yelling and screaming at the resident, Staff #22 stated I have heard her speak to another resident like that, she does not know how to control her anger.<br><br>An attempt was made to interview (CNA/Staff#30) on March 20, 2025 at 1:42 pm, Message was left for a return phone call.<br><br>A review of the facility reportable event report with discover date of March 19, 2025 revealed multiple staff witnesses reporting staff #7 yelling and curing at resident #2. Interview with staff #7 revealed staff #7 stated I got loud with resident #2.<br><br>An interview as conducted on March 10, 2025 at 4:18 pm with Director of Nursing (DON/Staff#15). Staff #15 stated all new hires are provided with Crisis Prevention Intervention (CPI) training and at annual renewal classes. Staff #15 stated the trainings involve real life scenarios and mock drill. Staff # 15 stated if there are any outbursts from residents, the staff will have a huddle and will reflect for prevention instead of reaction. Staff #15 stated the expectation for alleged staff to resident abuse is to remove the person hat is named-interview, suspend immediately, interview all staff that work the unit and staff off the unit and based on the results of the investigation will terminate their employment or have them return to work. Staff #15 stated CNA #5 admitted to the incident involving resident #1 and the facility has substantiated their investigation. Staff #15 stated in regards to resident #2, the facility will also substantiate and that both CNA #5 and CNA#7 will be reported to the State Board of Nursing. Staff #15 stated that it is her expectation that any suspected abuse is reported right away and has been discussed in abuse and that Staff should not make the decision when to report. Staff #15 stated it has never been the facility's practice to record allegations of staff to resident abuse, only resident to resident abuse.<br><br>Review of the abuse policy tilted Abuse Program Policy and Procedure revised November 2017 states Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. |