

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 03/24/2025
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 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50887</p> <p>Based on record review, staff and resident interviews, facility documentation, and facility policy and procedure, the facility failed to ensure adequate supervision to prevent a non-prescribed medication overdose for one resident (#12). The deficient practice could result in an avoidable accidental overdose of residents.</p> <p>Findings Include:</p> <p>-Regarding Resident #24:</p> <p>-Resident #24 was admitted to the facility on [DATE] with diagnoses that included asthma, major depressive disorder, and opioid use with unspecified opioid induced disorder.</p> <p>A care plan-initiated [DATE] revealed no focus related to substance abuse or dependency.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated on [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated resident was cognitively intact.</p> <p>Review of a Nurse Practitioner (NP) progress note dated [DATE] at 4:14 PM revealed that the resident reported recent methamphetamine abuse, and reported trying to refrain from use.</p> <p>An interview was conducted on [DATE] at 1:29 PM with Resident #24 who stated that he did give fentanyl to Resident #12, but could not remember the exact date, only that it occurred around the end of February 2025 or beginning of [DATE]. Resident #24 also stated that he believed it was the reason why Resident #12 went to the hospital.</p> <p>In a follow up interview with resident #24 conducted on [DATE] at 2:49 PM, the resident stated that he obtained the fentanyl from outside the facility. He further stated that the individual that he obtained the fentanyl from was not a staff member or associated with the facility.</p> <p>-Regarding Resident #12</p> <p>Resident #12 was admitted to the facility on [DATE] with diagnoses that included esophageal obstruction, anxiety disorder, and long-term use of opiate analgesic.</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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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>A quarterly MDS assessment dated on [DATE] revealed a BIMS score of 14 which indicated that the resident was cognitively intact.</p> <p>The resident's care plan revealed a focus for a known history of substance abuse related to poisoning by other opioids, accidental. Interventions included administering medications as ordered, monitor for side effects, report to the physician as needed, and encourage the resident to communicate triggers as needed.</p> <p>A nurse's progress note dated [DATE] at 1:02 PM revealed Resident #12 was found in bed unresponsive around 12:15 PM, oxygen and cardiopulmonary resuscitation (CPR) were initiated. The note revealed that there was mouth foaming and some residual at the nose noted. Upon ambulance arrival the resident was responsive to some questions and was then transferred to the hospital.</p> <p>A nurse's note dated [DATE] at 6:43 PM revealed that the resident was admitted to the hospital for observation.</p> <p>A hospital visit summary dated [DATE] revealed that a urine drug screen for Resident #12 was positive for oxycodone, fentanyl, and benzodiazepines.</p> <p>Review of physician's orders revealed no evidence of an order for fentanyl.</p> <p>An interview was conducted on [DATE] at 1:31 PM with resident #12 who stated he went to the hospital on [DATE] due to a fentanyl drug overdose. The resident stated that he obtained the fentanyl from outside the facility from an individual who is not affiliated with the facility. The resident further stated that he did not receive any medications that were not prescribed to him from anyone in the facility. Resident #12 further stated that Resident #24 was his previous roommate in the facility.</p> <p>An interview was conducted on [DATE] at 2:56 PM with a Licensed Practical Nurse (LPN/Staff #27) who stated that residents were not allowed to keep medications in their room unless specifically indicated. The LPN also stated that if observed that a resident had illicit drugs or prescriptions that were not prescribed to them that she would alert the supervisor. The Staff #27 stated that she was not aware of any interventions that were in place to prevent a resident from obtaining non-prescribed medications or other illicit substances. Staff #27 also stated that she was aware of the incident that occurred on [DATE] regarding Resident #12 and stated that it was suspected that the resident, got something and overdosed on it. Staff #27 stated that she was not aware of what Resident #12 had taken or where he had obtained the substance from.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>An interview was conducted on [DATE] at 3:26 PM with an LPN (Staff #3) who stated that he was usually assigned to the locked units of the facility so it was not an issue with resident's bringing in illicit substances or non-prescribed medications because the residents do not leave the unit. Staff #3 also stated that he had heard of residents who are not on the locked units bringing things into the facility. Staff #3 stated that an intervention to prevent residents from bringing in non-prescribed medications or illicit substances included searching the resident's room if they are suspected of using illicit drugs or behaving differently. Staff #3 stated that he was aware of the incident that occurred on [DATE] regarding Resident #12, and stated that the resident was found in his room unresponsive so cardiopulmonary resuscitation (CPR) was initiated and 911 was called. Staff #3 further stated that Resident #12 was suspected to have overdosed on a substance and that there was residual powder around the resident's nose. Staff #3 stated that staff did find some substance in Resident #12's room but were not sure what it was.</p> <p>In an interview conducted on [DATE] at 3:46 PM with the Assistant Director of Nursing (ADON/ Staff #42), the ADON stated that interventions to ensure there are no illicit substances in the facility included: asking the residents if they had illicit substances, drug screenings, and room searches. The ADON stated that the facility would need to obtain consent prior to administering a drug screen or searching the resident's room. The ADON also stated that they educate residents about the dangers of using illicit substances, especially if the resident is currently taking a narcotic. The ADON stated that interventions were in place to prevent a resident from obtaining outside non-prescribed medications or illicit substances which included: the physician could limit the resident going outside the facility on a pass, counseling, and outpatient rehabilitation or other services other than what the facility can provide. The ADON stated that there was one suspected incident of a resident sharing a non-prescribed medication with another resident. However, no residents have stated that they had shared a non-prescribed medication with another resident. The ADON further stated that Resident #12 told the facility he had obtained the non-prescribed medication from outside of the facility and would not tell the facility what the substance was. The ADON confirmed that the hospital records revealed a urine drug screen that was positive for fentanyl, and a suspected drug overdose for Resident #12.</p> <p>Review of the facility policy, Safety and Supervision of Residents, revised [DATE], revealed that resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The policy indicated that the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision. The policy also revealed that resident supervision is a core component of the systems approach to safety.</p>		