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	05/27/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50166 Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#32) did not abuse another resident (#121). The deficient practice could result in residents being physically harmed. Findings include: -Resident #32 was admitted on [DATE] with diagnoses that included pityriasis versicolor, bipolar disorder, aphasia, mild neurocognitive disorder, psychoactive substance abuse, history of traumatic brain injury, and schizoaffective disorder bipolar type. Review of a care plan initiated on May 4, 2023 revealed no evidence of physical behaviors or the incident that occurred between the two residents. An Annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated the resident was severely cognitively impaired. The assessment also indicated no behaviors were exhibited. A progress note dated June 1, 2024 at 3:58 p.m. revealed that the resident was being physically and verbally aggressive with staff and trying to hit them while attempting to leave. The progress note revealed that three staff members attempted to contain the aggressive behaviors, but ultimately the police were called. The progress note further revealed that the resident hit another resident before he was placed on 1:1 supervision. An Interdisciplinary Team note dated June 3, 2024 at 12:06 p.m. revealed that the resident had an episode of physical aggression on June 1, 2024 with another resident, and the interventions were to separate the residents, place the resident on a 1:1 supervision until a unit change was completed. -Resident #121 was admitted on [DATE] with diagnoses that included dementia with agitation, type 2 diabetes, bipolar disorder, anxiety, altered mental status, adjustment disorder, conduct disorder, major depressive disorder, post-traumatic stress disorder, and psychosis. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated June 1, 2024 at 2:42 p.m. revealed that the resident was in the dining room attempting to ambulate around another resident when the aggressor pulled the resident down to the floor. The progress note revealed that the resident was first on his knees, then he fell to the ground before he was assessed for pain and injuries. An Admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. Review of a care plan initiated on June 7, 2024 revealed a focus on physically aggressive behaviors related to dementia. Review of the facility investigation dated June 4, 2024 revealed that Resident #121 was attempting to ambulate near Resident #32 in the dayroom when Resident #32 grabbed Resident #121 ' s leg and pulled him to the ground. The investigation revealed that Resident #121 fell on to his knees, was assessed for pain and injuries, and no injuries were found. The investigation further revealed that the two residents were separated immediately, and Resident #32 was put on 1:1 supervision until a unit change could be completed. The investigation revealed that the facility substantiated resident to resident abuse. An interview was conducted on May 27, 2025 at 2:12 p.m. with a Certified Nursing Assistant (CNA/Staff#52) who stated that he recalled observing the incident between Resident #32 and Resident #121. The CNA stated that Resident #32 grabbed Resident #121 ' s ankle; and then, escorted Resident #32 back to his room after getting assistance from the nurse to assess Resident #121. A telephonic interview was attempted with no response on May 27, 2025 at 2:21 p.m. with a Licensed Practical Nurse (LPN/Staff#170) who witnessed the incident. An interview was conducted on May 27, 2025 at 2:28 p.m. with the administrator and Abuse Coordinator (Administrator/Staff#43) who stated that there was an incident between two residents in which one resident grabbed another resident's leg and pulled him to the ground. The administrator stated that the staff separated the residents, placed Resident #32 on 1:1 supervision, and completed a unit change for Resident #32. The administrator stated that they usually do a good job of preventing altercations like this, but this incident they did not prevent because the resident just grabbed at the other resident, which resulted in the facility substantiating their investigation of resident to resident abuse. Review of a policy titled, Resident Rights, was revised in December of 2016 and revealed that residents should be free from abuse, neglect, misappropriation of property, and exploitation. Review of a policy titled, Abuse Program Policy and Procedure, was revised in November of 2017 and revealed that residents had the right to be free from abuse, and furthermore the facility would ensure that residents were not subjected to abuse by anyone, including other residents. The policy revealed that the facility would prevent and prohibit all types of abuse, and it also defined physical abuse as hitting, slapping, pinching, and kicking.