

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 07/03/2025
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)
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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and staff interviews, the facility failed to protect the rights of one resident #222 to be free from abuse by another resident #333. The deficient practice could result in further abuse. Findings include: -Resident #222 was admitted on [DATE] with diagnoses that included unspecified intracranial injury with loss of consciousness. An MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 04, which indicated that the resident was severely cognitively impaired. Progress note dated April 14, 2024 revealed that Resident #222 was observed sitting outside during a smoke break when Resident #333 stood up, turned around, hit Resident #222 in the face. Further, the progress note revealed that Resident #222 had been immediately separated from the location of the incident, and assessed for any pain and injuries. The progress note also revealed that mild redness was observed on Resident #222's face. The progress note also revealed that Resident #222 was moved to a different unit following that incident. A skin assessment with the completion date of April 14, 2024 confirmed documentation of mild redness on the face of Resident #222. -Resident #333 was admitted on [DATE] with diagnoses that included schizoaffective disorder, bipolar type. MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 06, which indicated resident was severely cognitively impaired. Progress note dated April 14, 2024 revealed that Resident #222 had been observed sitting outside during a smoke break when Resident #333 stood up, turned around, hit Resident #222 in the face. Further, the progress note revealed that Resident #333 had been immediately separated from the location of the incident, and assessed for any pain and injuries. An interview was conducted Licensed Practical Nurse (LPN/Staff #88) on July 3, 2025 at 11:10AM, who stated that abuse can be in the form of verbal, physical, misappropriation of property, emotional; and, as well as neglect. Staff #88 stated that although they did not witness the incident between Resident #222 and Resident #333, if a resident to resident incident occurred in a common area, such as the designated smoking area, that it can be identified as abuse, and if not addressed per professional standards and facility protocol, may place residents and staff into immediate danger. An interview was conducted with a Certified Nursing Assistant (CNA/Staff #77) on July 3, 2025 at 12:13PM, who stated that abuse can be in the form of verbal, physical, emotional, sexual, and as well as misappropriation of property. Staff #77 stated that although they did not witness the incident between Resident #222 and Resident #333, if a resident to resident incident occurred in a common area, such as the designated smoking area, that it can be identified as abuse, if a resident harmed the other resident physically, mentally, verbally or emotionally. An interview was conducted with Resident #333 on July 3, 2025 at 1:40PM who recalled that residents have been a part of altercation that took place in the area that was designated for smoking. An interview was conducted with the Administrator (Staff #66) on July 3, 2025 at 2:26PM who stated that Resident #222 and Resident #333 were located in the designated smoking area when Resident #333 stood up from their seat and hit Resident #222 in the face, which had resulted in mild redness to Resident #222's face. Staff #66 stated that both residents had been separated; and that, Resident #222 had been placed in a room in which they felt safe in. Staff #66 also stated that both residents underwent assessments to determine further injuries. Staff #66 also stated that within their investigation, interviews were conducted with witnesses who confirmed the incident did occur. A facility policy titled Abuse Program Policy and Procedure revealed that abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. The policy also defined physical abuse to include hitting, slapping, pinching and kicking.</p>		