

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  07/15/2025
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, resident and staff interviews, and review of facility policy, the facility failed to protect the rights of one resident (#16) to be free from abuse from another resident (#3). The deficient practice could result in residents being physically or emotionally harmed. Findings include:-Resident #16 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, paraplegia, and obesity. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Review of the progress notes revealed a nurses' note, dated July 7, 2025 at 11:15AM, which revealed that Resident #16 was experiencing increased hallucinations, delusions, and false allegations towards staff and peers. Further review of the progress notes revealed a room change notice, dated July 7, 2025 at 1:57PM, which revealed that Resident #16 had his room moved to another hall. The reason listed was prevention. Review of the nurses note, dated July 7, 2025 at 8:17PM, revealed that police had called the facility unit wishing to speak to Resident #16, as he had requested to file a report against another resident for assault. The staff who wrote the note indicated that they had no knowledge of the alleged event. The note also indicated that Resident #16 declined to talk to police at the time. Review of the facility self-report investigation revealed that Resident #16 reported to his insurance case manager on July 7, 2025 that he was struck on the left side of his face by another resident. Resident #16 did not identify the resident at first, but later stated that it was Resident #3 who struck him. Interview was conducted on July 15, 2025 at 09:55AM with Resident #16, who confirmed that another resident had punched him in the face and attempted to choke him. When asked where exactly he had been hit, the resident pointed to his face, under his left eye. The resident reported that this incident occurred when he was on his previous unit and that the incident had occurred on a Thursday. The resident explained that the incident occurred in the hallway, as staff was pushing his wheelchair into a room. He also stated that staff and residents had seen the incident occur, and named a Life Enrichment Associate who saw it. Resident #16 stated that following the event, the staff took the other resident away, and staff assisted Resident #16 to go outside to smoke.-Resident #3 was admitted to the facility on [DATE] with diagnoses that included chronic systolic heart failure, dementia with other behavioral disturbance, and anemia. Review of the MDS dated [DATE] revealed a BIMS score of 0, indicating severe cognitive impairment. Review of the progress notes revealed an order administration note, dated July 3, 2025 at 6:00PM, which indicated that Resident #3 was administered Ativan for aggressive behavior. The note indicated that the resident was very aggressive and agitated. Interview was conducted on July 15, 2025 at 10:01AM with Resident #3, who denied recalling ever being involved in or witnessing any fights between residents. Interview was conducted on July 15, 2025 at 10:06AM with a Licensed Practical Nurse (LPN/Staff #4), who stated that she did not witness the altercation between Resident #16 and Resident #3, but had heard about it from a case worker. The LPN explained that Resident #16 had claimed that Resident #3 had choked him. Interview was conducted on July 15, 2025 at 11:00AM with a Life Enrichment Associate (Staff #7), who stated that on July 3, 2025, she was gathering the residents to watch a movie, when she witnessed Resident #3 hit Resident #16. She explained that this incident occurred as she was assisting Resident #16 toward the day room. The staff stated that Resident #3 approached Resident #16 and hit him in the face. The staff stated that the two residents were separated. When asked if this incident had been reported to anyone, including facility management, the staff stated that she was not sure if the incident had been reported, but stated that there was a nurse and Certified Nursing Assistants (CNAs) who had also seen the event occur. Staff #7 stated that an incident like this should typically be reported, and confirmed that this could be potential abuse. Further review of the facility self-report investigation revealed that three staff interviews were conducted from the staff that were working on July 3, 2025, who all denied witnessing the alleged altercation. However, there was no evidence that Staff #7, who directly saw the incident, was interviewed or provided a statement. Interview was conducted on July 15, 2025 at 12:22PM with the Executive Director (ED/Staff #35), who confirmed that she is the abuse officer for the facility. The ED confirmed that all staff receive annual and ongoing training on abuse, including the types of abuse, reporting, and who to notify. The ED stated that she would expect staff to notify their supervisor of potential abuse, who would then report to her, so that abuse can be reported to the appropriate agencies within two hours. The ED also stated that her process for investigating abuse included to interview the alleged victim, the alleged perpetrator, and then to interview ten percent of the residents on the unit and ten percent of the staff working</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, resident and staff interviews, facility documentation, and policy review, the facility failed to develop and implement policies and procedures for documenting and reporting alleged violations involving abuse, in accordance with federal and state laws and regulations. The deficient practice resulted in an alleged violation concerning abuse (involving Resident #16 and Resident #3) not being investigated timely and reported within the mandatory two-hour timeframe to Adult Protective Services (APS) and the State Agency. This deficient practice could result in further allegations not being documented or reported in a timely manner, which could impact residents' quality of life and care. Findings include: Regarding Resident #16 Resident #16 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, paraplegia, and obesity. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Review of Resident #16's progress notes revealed no evidence that any altercations or potential abuse situations had occurred on the night of July 3, 2025. Review of the nurses note, dated July 7, 2025 at 8:17PM, revealed that police had called the unit wishing to speak to Resident #16, as he had requested to file a report against another resident for assault. The staff who wrote the note indicated that they had no knowledge of the alleged event. The note also indicated that Resident #16 declined to talk to police at the time. Review of the facility self-report investigation revealed that Resident #16 reported to his insurance case manager on July 7, 2025 that he was struck on the left side of his face by another resident. Resident #16 did not identify the resident at first, but later stated that it was Resident #3 who struck him. Interview was conducted on July 15, 2025 at 09:55AM with Resident #16, who confirmed that another resident had punched him in the face and attempted to choke him. The resident reported that this incident occurred when he was on his previous unit and that the incident had occurred on a Thursday. The resident stated that staff and residents had seen the incident occur, and named a Life Enrichment Associate who saw it. Resident #16 stated that following the event, the staff took the other resident away, and staff assisted Resident #16 to go outside to smoke. Regarding Resident #3 Resident #3 was admitted to the facility on [DATE] with diagnoses that included chronic systolic heart failure, dementia with other behavioral disturbance, and anemia. Review of Resident #3's progress notes revealed no evidence that any altercations or potential abuse situations had occurred on the night of July 3, 2025. Interview was conducted on July 15, 2025 at 11:00AM with a Life Enrichment Associate (Staff #7), who stated that on July 3, 2025, she was gathering the residents to watch a movie, when she witnessed Resident #3 hit Resident #16. She explained that this incident occurred as she was assisting Resident #16 toward the day room. The staff stated that there was no sign of escalation, but that Resident #3 approached Resident #16 and hit him in the face. The staff stated that the two residents were separated. When asked if this incident had been reported to anyone, including facility management, the staff stated that she was not sure if the incident had been reported, but stated that there was a nurse and Certified Nursing Assistants (CNAs) who had also seen the event occur. Staff #7 stated that an incident like this should typically be reported, and confirmed that this could be potential abuse. Further review of the facility self-report investigation revealed that three staff interviews were conducted from the staff that were working on July 3, 2025, who all denied witnessing the alleged altercation. However, there was no evidence that Staff #7, who directly saw the incident, was interviewed or provided a statement. There was no evidence found that all witnesses and staff who worked with the residents were interviewed, as instructed in the facility policy. Interview was conducted on July 15, 2025 at 12:22PM with the Executive Director (ED/Staff #35), who confirmed that she is the abuse officer for the facility. The ED confirmed that all staff receive annual and ongoing training on abuse, including the types of abuse, reporting, and who to notify. The ED stated that she would expect staff to notify their supervisor of potential abuse, who would then report to her, so that abuse can be reported to the appropriate agencies within two hours. The ED also stated that her process for investigating abuse included to interview the alleged victim, the alleged perpetrator, and then to interview ten percent of the residents on the unit and ten percent of the staff working. The ED stated that the risk of abuse not being reported would be that the facility cannot act to prevent further harm. When asked about the altercation between Resident #16 and Resident #3, the ED stated that she first became aware of the incident through Resident #16's insurance case manager. The ED then explained that when interviewed, Resident #16 could not tell them the date the incident occurred, only that it was a Thursday, and the resident also did not name any witnesses. The ED</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record reviews, facility documentation, and staff interviews, the facility failed to ensure that an alleged violation involving abuse (involving Resident #16 and Resident #3) was reported to the State Agency and Adult Protective Services (APS) within the required timeframe of two hours. The deficient practice could cause a delay in response to potential abuse, putting residents at risk. Findings include: Regarding Resident #16 Resident #16 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, paraplegia, and obesity. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. 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The ED then explained that when interviewed, Resident #16 could not tell them the date the incident occurred, only that it was a Thursday, and the resident also did not name any witnesses. The ED stated that her investigation included interviewing some of the staff working the previous Thursday, though she could not verify that any staff witnessed the altercation or that abuse had occurred. Review of the facility policy titled, Abuse Program Policy and Procedure, revealed that employees must immediately report any suspected abuse or incidents of abuse to the Administrator and/or designee. The policy also indicated that all alleged violations involving abuse, neglect, exploitation or mistreatment should be reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p>		