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	12/02/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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	12/02/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a closed record review, staff interviews, review of facility documentation, policy, and procedures, the facility failed to ensure that the resident's representative was notified of an injury for one resident (#222). The deficient practice could result in resident representatives not being informed of resident's injuries. Findings included:Resident #222 was re-admitted on [DATE] with a diagnosis that included Senile degeneration of brain, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic chronic kidney disease, major depressive disorder, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.A review of the electronic health record progress notes dated from October 19, 2025 to October 24, 2025 revealed discoloration observed at multiple places on the resident's body, along with the Physician's orders for X-ray for the resident #222; however, the progress notes revealed no documentation that the family had been notified subsequent to the injury or incident.A review of the MDS (minimum data set) dated October 14, 2025, revealed a BIMS (Brief Interview of Mental Status) score of 00, which indicated severe cognitive impairment. Resident #222 requires one-person maximum assistance.An interview was conducted on October 24, 2025, at 10:01 AM, with Licensed Practical Nurse (LPN/Staff #260). Staff #260 stated that LPN responsibilities included administering medications, monitoring patient conditions, and performing regular skin assessments. Staff #260 confirmed a bruise on the resident's right shoulder while assisting her for breakfast. Staff #260 stated that when hospice arrived for resident's shower, they called me (Staff #260) to assess the area since hospice employee had noted the discoloration. Staff #260 stated had observed a bruise on the right shoulder (approx. 1 cm x 2-3 cm), and a yellow discoloration on the left inner thigh (approx. 0.5 cm x 1 cm); and that, the weekend and night nurses had also noted the shoulder bruise. Staff #260 stated that hospice visits the resident twice weekly for showers and clothing changes.An interview was conducted on October 24, 2025, at 02:17 PM. with a Certified Nursing Assistant (CNA/staff #250). Staff #250 stated that for unwitnessed falls, the nurse is notified immediately to assess for injuries, assist the resident, report to the family and DON/ADON, and document the incident. Moderate-risk residents have fall mats and are kept within sight; high-risk residents receive one-on-one monitoring, fall mats, and low bed positioning. For Resident #222, the CNA reported bruising on her right shoulder and hip on Monday. No falls were reported; however, fall mats are in place, as she sometimes crawls out of bed.An interview was conducted on October 24, 2025, at 2:30 PM with LPN (staff #245). Staff #245 stated that fall risk assessments are completed upon admission and reviewed weekly, biweekly, monthly, or annually based on the resident's condition. For unwitnessed falls, neuro checks are performed, an incident report is completed, and the nurse must immediately notify the family, physician, and supervisors after the assessment, even if no injuries are observed. All falls, whether witnessed or unwitnessed, must be documented. Resident #222, experienced an unwitnessed fall on Friday, October 17th, around 9 PM. Staff #245 stated had found the resident sitting on the floor and assessed her thoroughly; her skin was intact with no bruising or injuries noted. She was calm and comfortable, showing no signs of pain or distress. I did not notify the family or supervisors at that time, as it was near the end of my shift and I was off over the weekend. I acknowledge this was an error on my part for not reporting the incident promptly.A telephonic interview was conducted on October 24, 2025 at 3:21 PM with the resident's representative, RR #200 who stated that the resident had been injured at the facility; and that, she had received no notification from the facility. RR #200 stated was later notified by the Hospice staff on October 20, 2025.An interview was conducted on October 24, 2025, at 3:36 PM with the Director of Nursing (DON# #230). Staff #230 stated that for an unwitnessed fall, the resident is assessed immediately, injuries are treated, and safety is ensured. If needed, the resident is sent to the hospital. When no injuries are found, neuro checks are done, and the doctor, family, guardian, and case manager are notified. The nurse must document the incident, complete a risk report, and inform supervisors. Regarding resident #100, the staff # 230 was notified two days after her fall, which occurred on Friday but was initially reported as Saturday. The family was informed once it was confirmed on Monday. This delay did not meet facility expectations, and the staff # 245 was reeducated on the importance of timely reporting and communication.A review of the facility policy entitled Assessing falls and their causes, revised March 2018 revealed that the facility shall notify the resident's physician and family in an appropriate time frame. The policy further revealed that notification of the physician and family, as indicated, should be recorded in the resident's medical records.