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	03/20/2026

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** Based on clinical record review, staff and resident interviews, and facility policy, the facility failed to protect the rights of one Resident (#6) out of the five sampled residents to be free from abuse by another resident (#10). The deficient practice could result in other residents being abused.The facility census was 168. Finding include--Regarding Resident #6 (Alleged Victim)Resident #6 was admitted to the facility on [DATE], with diagnoses that included anoxic brain damage, mood disorder, depression, post-traumatic stress disorder (PTSD), and speech disturbance.A care plan initiated on May 20, 2025, revealed that the Resident #6 had been screened for traumatic history and is positive for adult sexual abuse, child physical abuse, domestic violence, and other vehicular victimization. The intervention included Resident #6 will be encouraged to socialize with other residents that have a similar history as opportunity allows and staff members would seek to avoid re-traumatization by minimizing resident triggers.A quarterly MDS (minimum data set) dated February 11, 2026, revealed that the resident had a BIMS (brief interview for mental status) score of 9, which indicated moderately cognitive impaired.A nursing note dated March 14, 2026, revealed that the Licensed Practical Nurse (LPN, staff #253) observed Resident #6 on the floor and crying. Per document, Resident #6 was non-verbal but admitted being pushed to the floor by another Resident #10. Per note, Resident #6 was assessed and no injury was noted but Resident #6 had pain on the head due to hitting head and knee.A weekly skin assessment dated [DATE], revealed that the Resident #6 had no breakdowns, open areas or areas of concerns.An interview was conducted on March 20, 2026, at 11:58 a.m., with Resident #6 and she responded to the answer by giving a thumbs-up sign. Resident #6 then stated that she recalled the incident between her and Resident #10 and the incident happened in the activity room. Resident #6 then stated that Resident #10 hurt her, and she got injured on her left head and it made her feel scared at the time of the incident.-Regarding Resident #10 (Alleged Perpetrator)Resident #10 was admitted to the facility on [DATE], with diagnoses that included anoxic brain damage, bipolar disorder, anxiety, seizures, and cognitive communication deficit.A care plan initiated on February 7, 2025, revealed that Resident #10 had been screened for traumatic history and is positive for substance abuse, and diagnosed with mental health disorder. The interventions included Resident #10 would be monitored for increased signs and symptoms of depression and reporting to the psychological provider as needed.A quarterly MDS (minimum data set) dated February 3, 2026, revealed that the resident was a BIMS (brief interview for mental status) score of 15, which indicated intact cognition.A nursing note dated March 14, 2026, revealed that the Licensed Practical Nurse (LPN, staff #176) was on the unit when yelling and commotion were heard coming from the activities area. Per note, the LPN observed a female resident seated on the floor and Resident #10 in his wheelchair yelling that she had been talking to another man. Resident #10 was re-directed back to his room and encouraged to remain calm. Per note, Resident #10 was advised that aggressive behavior toward others was not permitted, even when feeling upset. The psychiatric provider was notified, and Resident #10 was transferred to hospital for further evaluation of increased physical aggression.An interview was conducted on March 20, 2026, at 10:12 a.m. with an LPN (Staff #253). (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN stated that there are different types of abuse, including physical, verbal, and emotional. Per Staff #253, the facility process for a resident-to-resident altercation would be to separate both residents, notify the abuse coordinator immediately, and assess both residents for injuries. The LPN stated that she recalled the incident between Resident #6 and Resident #10. LPN then stated that on March 14, 2026, around 2 or 3 p.m., two staff members Activity and CNA (certified nursing assistance) came to her unit and stated that Resident #10 pushed Resident #6 and she was on the floor in the activity room. The LPN went to activity room and found Resident #6 on the floor and crying. The LPN stated that Resident #6 was non-verbal and can respond only by typing on her phone. Staff #253 stated another resident, Resident #4 witnessed the incident and informed her that Resident #6, #10, and #4 were playing karaoke in the activity room. Resident #6 was observed on her phone and Resident #10 thought Resident #6 was chatting with someone. Resident #10 then tried to grab Resident #6's phone and she refused to give her phone to him. Resident #10 then got angry, screamed, and grabbed Resident #6 from her neck area and both residents fell. Resident #10 stood up after fall but Resident #6 couldn't do so and started crying. Resident #10 was redirected to his room and Resident #6 was assessed for any injuries. The LPN further stated that she will consider the incident as resident to resident physical abuse Because Resident #10 was the one who put his hand on Resident #6.An interview was conducted on March 20, 2026, at 11:05 a.m. with a Life Enrichment Associate (Staff #215). Per Staff #215, physical abuse could be either hitting someone or unwanted touch. Staff #215 stated that she recalls the incident between Resident #6 and #10 and it happened on Saturday March 14, 2026, around 3 p.m. The 3 residents #6, #10, and #4 were in the activities room when Resident #10 saw Resident #6 was watching a video on her phone and got upset. Resident #10 then started yelling and using F and B' words at Resident #6, then dragged her down to the floor. The Resident #10 also stated to Staff #215 that resident #6 hit the left side of her head on the table before falling on the floor. Staff #215 further stated that she would consider this as a physical and emotional assault then an abuse because abuse is ongoing and assault is a one-time thing.An interview was conducted on March 20, 2026, at 11:36 a.m., with Resident #4. She stated that she knew Resident #6 and she is her best friend. Resident #4 then stated that she knew Resident #6 and #10 were dating at one point. Resident #4 further stated that the incident between Resident #6 and #10 happened last week on Saturday, March 14, 2026, in the activity room. The three residents were playing karaoke in the activity room. Resident #6 was observed watching a video on her phone and Resident #10 leaned his head on Resident #6 to look over her phone and then tried to grab her phone and Resident #6 stated No. Resident #10 then started yelling F and B words to Resident #6 and then stood up, leaning on her, using both of his arms to scoop her neck into his armpit and force her up from the wheelchair. Resident #6's head landed on the table first and then both Resident #6 and #10 landed on the floor. Resident #10 then started yelling, I hate you, f b, I will kill you, you cheated on me. Resident #6 then started crying and appeared scared and told Resident #4 not to leave her alone. Resident #6 then called the police. Resident #4 further stated that she considers this as a physical and verbal abuse.An interview was conducted on March 20, 2026, at 12:06 p.m., with Resident #10 who stated that he thinks the incident happened either on March 13 or 14, 2026. Resident #10 further stated that he was trying to take Resident #6's phone and she reacted to him by saying No. Resident #10 then pulled Resident #6 from her wheelchair because she was cheating on him. Resident #10 further stated that he was not sure whether Resident #6 got hurt or not. Resident #10 also stated that he did not get hurt during the incident.An interview was conducted on March 20, 2026, at 2:32 p.m., with a Director of Nursing (DON, staff #141). He stated that there are different types of abuse including physical, verbal, and sexual. DON then stated, as per facility process for physical abuse, residents are separated, making sure they are safe, notify the family, Arizona Department of Health services (AZDHS), Adult Protected Services (APS), and Ombudsman within 2 hours, and continue to do the investigation. The DON then stated that the incident between Resident #6 and #10 happened on March 14, 2026, and was reported to him by LPN (staff #176). The LPN stated that Resident #6 was on her phone when (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10 approached her. LPN then stated that Resident #10 grabbed Resident #6 and pulled her out of her wheelchair. Resident #6 expressed that she was scared and called 911 from her phone. Resident #10 was assisted back to his room and staff sat with him one-on-one. Resident #6's skin was assessed and denied any injury but was in pain. The DON further stated that he will consider this as physical abuse due to a report of one resident being pulled from a wheelchair by another resident.Review of the facility policy titled, Resident Rights, revised in December 2016, revealed that all residents would be free from abuse, neglect, misappropriation of property, and exploitation.Review of the facility policy titled, Abuse Program Policy and Procedure, revised in December 2016, revealed that physical abuse included hitting, slapping, pinching, and kicking. It also included controlling behavior through corporal punishment.