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	05/22/2026

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, facility documentation, and staff interviews, the facility failed to protect the right to be free from physical abuse for two residents (Residents #170, #171). The deficient practice could lead to additional resident-to-resident altercations, creating an unsafe environment. Findings include:-Resident #170 (alleged victim) was admitted to the facility on [DATE], with diagnoses that included Borderline Personality Disorder, Major Depressive Disorder, Hereditary idiopathic nervous system, and degenerative disease of the nervous System.The care plan focus problem initiated on January 21, 2019, revealed that resident #170 has a behavior problem related to personality disorder like staff splitting, making false accusations toward staff, being verbally abusive toward staff, and using manipulation to get what she wants.The annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has a Brief interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact. Review of skin assessment dated [DATE], revealed no skin breakdowns, open areas of concern.-Resident #171 (alleged perpetrator) was admitted to the facility on [DATE], with diagnoses that included Mood disorder due to known physiological condition, schizophrenia, borderline personality disorder, Suicidal Ideation and Paraplegia.The care plan focus problem initiated on March 27, 2024, revealed that the resident has a psychosocial well-being problem related to borderline personal disorder. Further review of the resident's care plan indicated that resident has been screened for traumatic history and is positive for domestic violence, elder abuse, child sexual abuse, stalking, driving under the influence, and mental health disorder.The annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the residents has a BIMS Score of 14, indicating cognitively intact. A review of the resident's medication record dated on May 27, 2024, revealed that resident was prescribed Desvenlafaxine 50mg (an antidepressant), and Ziprasidone 20mg (an antipsychotic medication), Lorazepam 1mg (anti-anxiety medication).Further review of the resident's medication record dated on April 22, 2024, indicated that resident's behavior was being monitored daily.Review of skin assessment dated [DATE], revealed no skin breakdowns, open areas of concern.The facility report dated on May 1, 2024, revealed that two residents (Resident #171 and #170) of Desert Cove in room [ROOM NUMBER] were arguing over the TV volume. Resident #171 said that resident #170 came to her bedside, which made her afraid, so she scratched resident #170 on her arm. Resident #171 said that resident #170 took her glasses and broke them. The residents were separated. Resident #170 indicated that she was trying to get resident #171's remote to turn her TV volume down. Resident #170 says that is when resident #171 scratched her right forearm area. Resident #171 said that resident #170 broke her glasses. Resident #170 denies breaking resident #171's glasses. Resident #171 was placed on one-on-one supervision until a room and unit change could happen.The behavioral note for Resident #171 dated May 01, 2024, revealed that while Licensed Practical nurse (LPN/ staff #129) was assessing roommate's arm for injury, resident #171 stated loudly, Yes, I scratched her, she was going to take my TV remote. The resident was placed on one-on-one before she was transferred to the other room.Review of Resident #170's change of condition progress note, included in the facility incident report, revealed that the resident #170 stated, (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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(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	My roommate scratched me, please have the nurse come take care of it. The nurse assessed the resident and resident #170 stated that, Her volume was too loud, so I went to turn it down and she scratched me. The assessment revealed three one-inch abrasions to the underside of the forearm and one approximately one-inch abrasion to the posterior forearm. On May 20, 2026 at 9:40 a.m., during a phone interview with the Certified Nursing Assistant (CNA/ Staff #115), she stated that she heard residents yelling at each other when passing out snacks. The CNA added that she remembered resident #170 saying that a resident scratched her. She stated that she didn't witness a physical fight, but resident #170 tends to instigate or pick at the other resident (#171), which led to an argument or fight.On May 20, 2026, at 10:02 a.m., during a phone interview with a LPN (Staff #129), she stated residents #170 and #171 were in the same room when the incident happened. She added that resident #170 came to the nursing station and reported that the resident refused to be in her room with resident #171. She added that resident #170 reported that she didn't want to go back to her room because resident #171 yelled at her. The LPN added that she remembered telling the resident to call staff if she needed anything. Staff #129 stated that she didn't witness resident #171 scratch resident #170, but resident #171 told her that she scratched resident #170 because of the TV remote. She stated that she remembers the facility interviewing her regarding the incident as part of the investigation.On May 22, 2026, at 11:38 a.m., the Administrator (Staff #48) was interviewed. After review of incident report she stated that she remembered placing the resident on one-on-one care until she was transferred to a different unit and substantiated the incident. She added that, based on current practice, if there's a resident-to-resident altercation, the alleged resident receives one-on-one care until transfer to a different room or unit. She stated that the risks could lead to further fighting if there's no intervention.Review of the policy titled, Abuse Program Policy and Procedure, revealed, that residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.