

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/22/2026
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy review the facility failed to ensure one of thirty-three sampled residents (#36) was free from physical restraint related to bed rails. The universe was one hundred and seventy-eight. The deficient practice could cause a resident to suffer physical injury from entrapment or psychosocial harm related to restraint use. Findings include: Resident #36 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar disorder, dementia, and anxiety disorder. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident had severe cognitive impairment. The MDS also included that no form of restraints, including bed rails, and/or alarms were coded as in use. The MDS further indicated impairment on both sides for lower extremities, dependent for mobility, and is dependent for all self-care activities. The comprehensive care plan reviewed/revised on March 28, 2026 revealed no evidence that use of the bed rails or concave mattress were addressed with interventions implemented. The care plan identified that the resident had an Activities of Daily Living (ADL) self-care performance deficit and required total assistance in all areas. During an observation on May 19, 2026 at 11:39 AM, the resident was lying in bed with eyes closed and both half-length bed rails raised. A blue fall mat was noted on the floor to the side of the bed. During an observation on May 20, 2026 at 1:03 PM, the resident was lying in bed with eyes closed on a concave mattress, with both half-length bed rails raised and a blue fall mat was noted on the floor to the side of the bed. During this observation the resident had just received care from a Certified Nursing Assistant (CNA) (staff #250). Following the observation, Staff #250 was interviewed and staff #250 stated that the resident was a high fall risk, that is why there is a fall mat and bed rails are up. The current physician orders on May 21, 2026 revealed no evidence of any orders regarding use of bed rails on her bed. Further review of the physician's orders revealed an order for concave mattress to bed due to the resident's poor safety awareness, was ordered April 13, 2021. The Treatment Administration Record (TAR) on May 21, 2026 for May 2026 revealed no intervention or monitoring for use of resident's bed rails. The clinical record on May 21, 2026 revealed no evidence that the resident was assessed for the use of bed rails. The clinical record on May 21, 2026 revealed no evidence that signed consent was given by the guardian regarding use of bed rails. During an observation on May 21, 2026 at 9:31 AM, the resident was lying in bed with eyes closed on a concave mattress with half-length bed rails up on both sides of the bed and a blue fall mat was observed on the floor to the side of the bed. During an observation on May 22, 2026 at 12:02 PM, the resident was lying in bed on a concave mattress, her eyes were open and she was making eye contact but would not respond to questions. The bed was in the lowest position, a blue fall mat was to the side of the bed, and bed rails were up on both sides of the bed. During an interview on May 22, 2026 at 12:05 PM, the CNA (staff #250) stated she was unaware of any restraints or concave mattress currently in use. Staff #250 stated that the resident is a fall risk per her care plan and the bed rails prevent her from rolling off the side of the bed. Staff #250 further stated that she had previously rolled off the side of the bed and that she hadn't noticed any risks other than hurting herself by hitting a body part on the (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed rails, but that the resident uses the rails mostly for mobility. In an interview on May 22, 2026 at 12:41 PM, a licensed practical nurse (LPN/staff #101) stated that the bed rails are connected to the bed, one bar on each side of the bed, and the bed rails are used for turning. The LPN stated that the bed rails have always been in place. Staff #101 also stated that she does not consider it a restraint because the resident already had the concave mattress and the mattress was for her very high fall risk. Staff #101 looked into the resident's electronic health record and saw the concave mattress order but did not see an order for the bed rails and also did not see any indication of bed rail use in the resident's care plan. Staff #101 further stated that in her point of view that the resident has a bed rail not a grab bar, a grab bar is half the size of the bed rail. In an interview on May 22, 2026 at 1:50 PM with the Director of Nursing (DON/staff #12), the DON stated the facility process for bed rails is to get a physician order for the bed rail and enter it into the care plan prior to implementation. The DON additionally stated that concave mattresses are used for significant risk for falling out of the bed and the facility process is to get an physician order and enter it into the care plan prior to implementation. The DON reviewed the resident's electronic health record and stated there was an order for a concave mattress. The DON stated he did not see an order for the bed rails. He further stated he found no indication of bed rail use or concave mattress use in the resident's care plan. The DON stated that bed rails in use with a concave mattress would be considered a restraint. He stated that the risk would be psychological harm and/or getting stuck in between the concave mattress and the bed rail. Review of facility policy on Bed Safety and Bed Rails revealed that bed rails were defined as adjustable metal or rigid plastic bars that attach to the bed and the term bed rails includes side rails, safety rails, and grab/assist bars. The facility policy defined physical restraints as any manual method, device, or equipment that is attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement. The facility's policy further stated that the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Review of facility policy on Physical Restraint Application revealed that preparation for application of physical restraints includes verification of physician's order for the use of restraints, review of the resident's care plan to assess for any special needs of the resident, and assemble equipment and supplies needed.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and facility policy review the facility failed to ensure a comprehensive care plan with interventions was developed, revised, and implemented related to safety and prevention for two of thirty-three sampled residents (#36 and #30) regarding use of bed rails, concave mattress and use of nicotine. The universe was one hundred and seventy-eight. The deficient practice could result in the resident's needs not being met. Findings include: Regarding resident #36-Resident #36 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar disorder, dementia, and anxiety disorder. Review of the Morse Fall Scale dated November 11, 2025, completed post fall, revealed the resident was assessed as a high risk for falling with a score of 60.0. Further review of the assessment revealed the resident had a history of falls. The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident had severe cognitive impairment. The MDS also included that no form of restraints, including bed rails, and/or alarms were coded as in use. The MDS further indicated impairment on both sides for lower extremities, dependent for mobility, and is dependent for all self-care activities. A review of the comprehensive care plan last reviewed/revised on March 28, 2026 revealed no evidence that use of the bed rails on her bed, concave mattress on her bed, and being a fall risk were addressed with interventions implemented. The care plan further revealed that the resident has an ADL self-care performance deficit and requires total assist in all areas. The care plan mentioned falls as side effects to anti-anxiety medication and antipsychotic medication. During an observation on May 19, 2026 at 11:39 AM, the resident was lying in bed with eyes closed and both half-length bed rails raised. A blue fall mat was noted on the floor to the side of the bed. During an observation on May 20, 2026 at 1:03 PM, the resident was lying in bed with eyes closed on a concave mattress, with both half-length bed rails raised and a blue fall mat was noted on the floor to the side of the bed. During this observation the resident had just received care from a Certified Nursing Assistant (CNA) (staff #250). Following the observation, an interview was conducted with Staff #250 who stated that the resident was a high fall risk, that is why there is a fall mat and bed rails are up. The current physician orders on May 21, 2026 revealed no evidence of orders regarding use of bed rails on her bed or use of fall mat. Further review of the current physician's orders revealed an order for concave mattress to bed due to the resident's poor safety awareness that was ordered April 13, 2021. The Treatment Administration Record (TAR) on May 21, 2026 for May 2026 revealed no intervention or monitoring for use of resident's bed rails or for falls. The clinical record on May 21, 2026 there was no evidence that the resident was assessed or informed consent was given by the guardian for the use of bed rails. During an observation on May 21, 2026 at 9:31 AM, the resident was lying in bed with eyes closed on a concave mattress with half-length bed rails up on both sides of the bed and a blue fall mat was observed on the floor to the side of the bed. During an observation on May 22, 2026 at 12:02 PM, the resident was lying in bed on a concave mattress, her eyes were open and she was making eye contact but would not respond to questions. The bed was in the lowest position, a blue fall mat was to the side of the bed, and bed rails were up on both sides of the bed. During an interview on May 22, 2026 at 12:05 PM, the CNA (staff #250) stated she was unaware of any restraints or concave mattress currently in use. Staff #250 stated that the resident is a fall risk per her care plan and the bed rails prevent her from rolling off the side of the bed. Staff #250 further stated that she had previously rolled off the side of the bed and that she hadn't noticed any risks other than hurting herself by hitting a body part on the bed rails, but that the resident uses the rails mostly for mobility. In an interview on May 22, 2026 at 12:41 PM, a licensed practical nurse (LPN/staff #101) stated that the bed rails are connected to the bed, one bar on each side of the bed, and the bed rails are used for turning. The LPN stated that the bed rails have (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy is. During an interview conducted on May 22, 2026 at 1:50 PM, the director of nursing (DON/staff #12) stated that smoking must be supervised by activities and the risk of residents having vapes and nicotine pouches would be that the facility staff could not monitor the use of those items. The DON also stated that the residents do not need a physician's order for vapes and nicotine pouches and they did not need to include smoking in the care plan. The DON further stated that the facility must do a smoking assessment and did see a smoking assessment for resident #30 completed April 5th, 2026. A review of the current physician orders on May 22, 2026 revealed no evidence of any orders regarding use of nicotine products. Review of the facility's policy on Smoking Guidelines, that includes vaping devices and nicotine pouches under the definition of smoking, revealed that any resident with smoking-related privileges, restrictions, or safety concerns, including the need for close monitoring, shall have these issues documented in the resident's care plan, and staff shall be made aware of these concerns.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 3Number of residents cited: 1The facility failed to protect resident right to make informed decisions and choices for one resident.Based on review of clinical and administrative records, resident and staff interviews, and review of facility policy, the facility failed to protect one out of three resident's right (#20) to make informed decisions and choices. The deficient practice could lead to a vulnerable resident not understanding their legal rights.Findings include:Resident #20 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, schizoaffective disorder, major depressive disorder, recurrent, anxiety disorder, heart failure, chronic obstructive pulmonary disease, unspecifiedThe annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has a Brief interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment.The care plan problem focus date initiated on July 01, 2024, revealed that resident has used an anti-anxiety medication related to anxiety disorder. Initial interventions initiated on July 01, 2024 included observation for side effects such as increased risk of confusion, amnesia, and cognitive impairment that looks like dementia.Additional review of the resident care plan problem focus date initiated on April 19, 2024, revealed that the resident has a chronic Hemiplegia and neuropathy pain related to neuropathy and hemiparesis. Initial interventions initiated on April 29, 2024, and revised on January 15, 2026, revealed to be observed for side effects are increased agitation, restlessness, confusion, and hallucination, dysphoria.Review of the resident signed arbitration agreement dated on April 24, 2024, revealed that the document was signed by the resident. During further review of the resident arbitration agreement, there were no resident representative signatures.Review of the resident admission packet that was signed on April 24, 2024, and arbitration agreement is included in the resident's admission packet and signed the same day. Additional review of the resident's most recent annual Minimum Data Set (MDS), the MDS dated [DATE], revealed that the resident has a Brief interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment.An interview with the resident on May 21 at 8:48 a.m. found that she didn't know what arbitration is and didn't remember signing an arbitration agreement. When asked during the interview, she didn't know her current location, date, or time. During the interview, the resident appeared confused.On May 21, 2026, at 3:00 p.m., an interview with the Director of admission (staff #286) found that an arbitration agreement is a contract stating that future disputes-such as claims of neglect, abuse, or injury-will be resolved through private, binding arbitration rather than through the traditional court system. The staff added that the facility must present the contract in plain, accessible language and clearly explain what it means to the resident or their legal representative. The staff added that the arbitration agreement is included in the resident's admission Agreement Packet. The staff added that during admission, she makes sure to go through all the documents in the resident's admission packet with the resident and their family. She added that with an arbitration agreement, she makes sure the resident or their representative understands what arbitration is before they sign it. The staff added that a resident with a low Brief Interview for Mental Status (BIMS) must have a legal representative present who understands arbitration before signing the document. The admission staff reviewed resident #20's signed arbitration agreement and her annual Minimum Data Set (MDS). Staff #286 stated that, based on the resident's Brief Interview for Mental Status (BIMS) dated April 24, 2024, the resident should have a legal representative present.An interview with the administrator (staff #48) was conducted on May 22, 2026, at 11:38 a.m. During the interview, the administrator reviewed the resident #20 arbitration agreement in the resident's admission packet and stated that the resident signed the arbitration agreement. The administrator stated she didn't see a signature from the resident's legal representative on the arbitration agreement. The administrator stated that, (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the resident's low BIMS score, the resident is required to have a legal representative with her who can understand arbitration before signing the agreement. Review of the policy titled, Binding Arbitration Agreements, revealed that the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. And the resident or his or her representative acknowledges that he or she understands the agreement because the risks can be denial of a vulnerable resident's legal rights without their true consent.		