STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035120	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI Casa Nursing Center	330 South Pinnule Circle Mesa, AZ 85206

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** 47910 Based on clinical record reviews, resident and staff interviews, and review of facility documentation and policies, the facility failed to protect the rights of two residents (#30 and #20) to be free from abuse by a staff and another resident. The deficient practice could result in further abuse and injury of residents. Findings include: Regarding resident #30 Resident #30 was admitted to the facility on [DATE] with diagnoses of Covid-19, Type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease (COPD) and mild Protein-Calorie Malnutrition. Review of the 5-day Minimum Data Sat (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10 indicating resident had moderate cognitive impairment. Further review of the MDS revealed that the resident had no behaviors exhibited; and that the resident required extensive assistance with bed mobility, transfers, toilet use, and personal hygiene. The care plan dated July 10, 2023 revealed the resident needed assistance with ADL (activities of daily living) to maintain or attain the highest level of function. Intervention included to assist the resident with mobility and ADLs as needed. The NP (nurse practitioner progress note dated August 2, 2023 revealed that the resident was transferred to the facility for rehabilitation and continued medical management. Physical examination included that the resident was alert and oriented x 3. (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	Review of the facility's investigation report dated August 5, 2023 revealed that on August 3, 2023 at approximately 11:35 a.m. the resident reported to a certified nursing assistant (CNA/staff #108) that a licensed practical nurse (LPN/staff #100) threw thrown his television remote at him because his volume was too high; and that, the LPN removed the batteries from his television remote. Per the report, in an interview with the resident conducted by the facility, the resident reported that he did not like being alone so he had his TV on; and, he fell asleep and may have rolled onto his TV remote causing it to turn his TV up. The documentation also included that the resident reported that the (LPN/staff #100) came in his room and told him that he cannot have his TV on; and that, the LPN grabbed his remote, turned the TV down and left his room with his remote. The resident reported that the LPN came back in his room and tossed the remote back to him; however, the resident noticed that the batteries to his remote had been removed. Per the documentation, the resident screamed back at the LPN and used profanity that he wanted his batteries back; and, the LPN brought the batteries back and tossed them on his lap. The facility report also included documentation of an interview was conducted with (LPN/staff #100) conducted by the facility. The documentation included that the incident took place at approximately 2:00 a.m. on August 3, 2023 and the LPN (staff #100) reported that she went to the resident's room to turn down his TV because it was very loud and found the resident sleeping. She reported that she picked up his remote from the bedside table and turned the TV down. The LPN reported that the resident woke up and yelled at her to give the remote back to him as he was grabbing her hand. The LPN reported that this startled her and she dropped the remote; and, while she was picking up the remote she noticed that the back had fallen off so she replaced it and handed the remote back to the resident. She further stated that when she was stepping out of the door, she stepped on a battery, picked it up and handed the battery to the resident. Further, the LPN denied throwing the remote and batteries at the resident and reported that she underhand tossed the remote into the resident's lap because she was afraid that the resident would hit her. Continued review of the facility report revealed an email from another LPN (staff #184) addressed to the director of nursing (DON/Staff #11) dated August 3, 2023. The documentation that staff #184 was working with the alleged LPN (staff #100) the night of the alleged event. Staff #184 reported that the alleged LPN was walking into the resident's room and said that the resident needed to turn his TV down. She stated the alleged LPN then went to where staff #184 was and told staff #184 that the alleged LPN took the remote from the resident; and then, the alleged LPN walked away and came back to tell her that the alleged LPN gave the remote back to the resident but the alleged LPN took the batteries out of it. The documentation also included that the alleged LPN told staff #184 that the alleged LPN should open the resident's room door as the alleged LPN had closed it. It also included that staff #184 told the alleged LPN that she (referring to the alleged LPN) needed to open the resident's door immediately and the alleged LPN was not to close the resident's room door. Further, the email included that she heard a dayshift CNA reporting to the dayshift nurse that the resident reported that the alleged LPN had thrown the remote at the resident, had taken his remote and had given it back to him without the batteries. Further review of the facility investigative report revealed that the alleged LPN denied taking the resident's remote; but, there were statements from the resident and another LPN (staff #184) that the alleged LPN did. The facility concluded that the allegation of abuse was unable to be substantiated but there was a customer service issue with the alleged LPN. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the employee file of the alleged LPN (staff #100) revealed that a disciplinary action was taken for the alleged event; and that, the alleged LPN was terminated August 7, 2023 for failing to provide good customer service to a patient. A phone interview with the alleged LPN (staff #100) was attempted on June 5, 2024 at 2:10 p.m. but was unsuccessful. There was no answer and the alleged LPN did not return the call. A phone interview with the other LPN (staff #184) was attempted on June 5, 2024 at 2:12 p.m. but was unsuccessful. There was no answer and staff #184 did not return the call. In an interview with the Executive Director (ED/Staff #33) and the DON Staff #11) conducted on June 5, 2024 at 3:58 p.m., the ED stated that he unsubstantiated the allegation of abuse due to the interviews conducted with Resident #30 and the alleged LPN (Staff #100) The DON stated the alleged LPN was terminated due to her inappropriate behavior with the resident and based on the email submitted by another LPN (staff #184) who was on shift with the alleged LPN at the time of the incident had occurred. Regarding residents #15 and #20 -Resident #20 (alleged victim) was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, oropharyngeal phase and cerebral infarction without residual deficits. The care plan dated January 25, 2022 revealed that the resident was dependent on staff for meeting his emotional, intellectual, physical and social needs related to physical limitations. A care plan dated March 2, 2022 included that the resident had ADL self-care performance deficit related to limited mobility. The health status note dated January 5, 2023 revealed the resident was alert and oriented and was able to make needs known. -Resident #15 (alleged aggressor) was admitted on [DATE], with diagnoses of Parkinson's disease, delusional disorders, aphasia following cerebral infarction, and unspecified dementia. The care plan with revision date of October 14, 2029 included that the resident was at risk for change in mood or behavior due to medical condition, cognitive communication defect, depression and history of declining care and treatments. Interventions included medications as ordered and to consult with the resident on preferences regarding customary routine. The significant change MDS assessment dated [DATE] revealed that the resident was assessed to have short- and long-term memory problem; and that, the resident had moderately impaired cognitive skills for daily decision making. The behavior note dated January 3, 2023 included that the nurse was by the nurse station when the nurse heard someone yelling for help by the dining room. Per the documentation, resident #15 was holding another resident (#20) by the shoulders from behind. Both residents were separated from each other and resident #15 denied holding resident #20. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry event note dated January 4, 2023 included that the IDT (interdisciplinary team) reviewed the incident and had removed resident #15 from the situation and was being monitored by staff. Review of the care plan dated January 4, 2023 revealed the resident had the potential to be physically aggressive related to cognitive deficit and poor impulse control. Interventions included to administer medications as ordered, assess/anticipate needs and provide physical and verbal cues to alleviate anxiety. An alert note dated January 5, 2023 included that resident #15 was on alert for resident to resident altercation. Review of the facility investigation dated January 6, 2023 revealed that on January 3, 2023 at approximately 12:20 p.m., several staff heard resident #20 yelling in the dining room for help.PM in the dining room. The report included that a nurse and two CNAs witnessed resident #15 sitting in his wheelchair in front of the television in the dining room with resident #20 directly behind him. The documentation included that the hands of resident #20 were on the shoulders of resident #15 preventing resident #15 from propelling his wheelchair forward. The facility investigative report also included an interview conducted by the facility with resident #20 who reported that he was watching television and was about 6 feet away and facing the TV when suddenly resident #15 came from behind him and placed her hand on his shoulder. Resident #15 reported that he asked resident #20 what she wanted and resident #20 just told him that she was going to help him. Resident #15 also reported that when he tried to move away, resident #20 placed her other hand on his left shoulder and gripped his shoulders harder and essentially pinching and preventing him from moving. Continued review of the report revealed that a review of the facility's closed circuit TV was conducted during their investigation. Per the documentation, resident #20 was exactly in the position that he had reported and resident #15 was at a table approximately 12 feet away; and that, resident #15 was seen slowly wheeling behind resident #20. It also included that resident #15 gently placed her left hand on the shoulder of resident #20 who noticed her coming before she placed her hand on him. The documentation included that both residents had a brief conversation and after several minutes, resident #20 attempted to move and resident #15 was holding on tight by the time it took for the staff to remove her hands. Further review of the facility's investigative report revealed that the allegation was substantiated that resident #15 in fact gripped resident #20 to the point of hurting. An interview was conducted on June 5, 2024 at 12:38 p.m. with resident #20 who stated that resident #15 came up behind him and pinched the hell out of my shoulder. The resident stated he could not get resident #15 off of him or he could not get away because of the hold resident #15 had on his shoulders so he screamed for help. He stated five staff came and were able to pull resident #15 off of him. The resident stated that resident #15 pinching him caused a bruise on his left shoulder. He stated he had never had any issues with resident #15 prior and he had seen that resident #15 was extremely confused at the time. He stated the staff kept him and resident #15 separated after the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON (staff #11) and ED (staff #33) conducted at 3:37 p.m. on June 5, 2024, the DON stated that any time there was a resident to resident incident staff knows to immediately remove and separate the involved residents and notify both her and the ED. The DON further stated that resident identified as the aggressor will be monitored; and, if both involved residents were roommates, the staff will move the residents in a different room. Regarding the incident between residents #15 and #20, the ED stated he substantiated the incident due to the fact the incident did occur and caused resident #20 pain. Review of the facility policy titled Abuse-Prevention with a review date of July 18, 2023 revealed that it is their policy to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. It also included the facility will take steps to prevent physical abuse by any individual which included residents. The policy further included that physical abuse includes, but is not limited to hitting, slapping, punching, biting and kicking.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50116 Based on clinical record review, staff interviews, and facility documentation and policies, the facility failed to ensure care and treatment were provided for one resident (#10) according to professional standards of practice. The deficient practice resulted in the hospitalization of the resident. Findings include: Resident #10 was admitted to the facility on [DATE] with diagnoses of chronic hepatic failure, hypertension, congestive heart failure, chronic kidney disease with end stage renal disease, and hyperkalemia. The nutrition care plan dated 04/04/2024 included a goal for the resident's skin to improve. The skin integrity documentation dated 04/09/2024 included cellulitis and blisters to the left lower extremity (LLE) and right lower extremity (RLE). The provider note dated 04/10/2024 included that the resident had cellulitis on bilateral lower extremities (BLE) and edema. Treatment included antibiotics for 5 days which was noted as completed; and that, the problem still persisted. A physician order dated 04/10/2024 included a treatment to cleanse bilateral foot blister with NS (normal saline), pat dry, wrap with kerlix daily every day shift and as needed if soiled. A provider note dated 04/14/2024 revealed that the resident still had BLE swelling; and that, antibiotics were ordered for leg cellulitis. The physician order dated 04/15/2024 revealed an order to cleanse left lower extremity open blister with saline, apply non-adherent pad to open area and wrap with ace wrap one time a day for cellulitis. The skin integrity note dated 04/16/2024 included right and left lower extremity cellulitis with blisters. The skin integrity note dated 04/23/2024 revealed right and left lower extremity cellulitis (lymphedema) with blisters. The skin integrity dated 04/30/2024 included lymphedema. The Wound Observation Tool was dated 04/30/2024 revealed that the left lower extremity wound was unchanged and had large serous drainage. Wound measurement was 40 cm (centimeter) length x 40 cm (width) x 0 cm (depth). Per the documentation, there were no signs of infection and treatment included iodoform and kerlix dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound treatment orders for the bilateral foot blisters and the left lower extremity were transcribed onto the Treatment Administration Record (TAR) for April 2024 and revealed the resident refused treatment and dressing change on 04/15/2024; and, treatment/dressing change on bilateral foot blisters was not documented as administered on 04/14/2024, 04/21/2024, 04/26/2024 and 04/30/2024. Continued review of the TAR revealed that treatment/dressing change on the left lower extremity was not documented as administered on 04/21/2024, 04/26/2024 and 04/30/2024. The TAR for May 2024 revealed that the treatments for the bilateral foot blisters and the left lower extremity were documented as refused on 05/01/2024. Despite documentation of the wounds and treatment orders, the clinical record revealed no evidence that the resident's wounds were care planned with interventions. The clinical record revealed that the resident was transferred to the hospital on 05/02/2024 and returned at the facility on 05/15/2024. The physician orders dated 05/16/2024 included the following: -Cleanse the right foot with wound cleanser, pat dry, apply alginate with silver, cover with dry dressing, abd pad and secure with tubi grip every day shift for wound care; and, -Cleanse BLE with wound cleanser, pat dry, apply impregnated bismuth, cover with dry dressing, abd pad and secure with ace wrap every day shift for wound care. These orders were transcribed onto the TAR for May 2024 and revealed that treatment to the right foot and the BLE were documented as administered from 05/16/2024 through 05/21/2024. The clinical record revealed no documentation that the resident refused treatment for the right foot and the BLE. Further, the resident's refusal and/or noncompliance with wound care was not identified as a focus area with interventions placed in the care plan. Review of the nursing progress note on 05/21/2024 included that the resident remained non-compliant with wound care; and that, the wound doctor is aware. The documentation included that on this day, the resident allowed staff to change his bandages; and, upon removal of all the bandages from his LLE, maggots were noted on his foot. Per the documentation, the wound doctor was notified and orders were received to send the resident to the ER (emergency room) for evaluation and treatment. In an interview with the Assistant Director of Nursing (ADON)/Wound Nurse (staff #117) conducted on 06/05/2024 at 1:45 p.m., the ADON stated that she will first see the residents with wound, go with the wound provider on rounds; and, the only treatments that she performs were wound vacs and complex dressings. Regarding resident #10, the ADON said that Resident #10 did not have a complex dressing so she did not do the resident's wound dressing. The ADON stated that the staff nurses were responsible for the treatments of the resident #10's wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) was conducted on 06/05/2024 at 2:45 p.m. The DON stated that the expectation was for wound care to be documented in the TAR when they are completed. The DON said that if there was a concern, staff can document in a nursing note or they notify the wound nurse. Further, the DON said that besides the documentation of the TAR, the bandages are dated per the wound nurse. According to the Centers for Disease Control and Prevention (CDC), myiasis is a parasitic infection of fly larva (maggots) in human tissue and that people who have untreated or open wounds have a higher risk for getting myiasis. The CDC also noted that prevention is key to protecting oneself from myiasis and precautions to take include cover open wounds.