

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER MI Casa Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 330 South Pinnacle 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51728</p> <p>Based on review of records and staff interviews, it was revealed that the facility failed to ensure that dignity was maintained for one resident (#33). The deficient practice could result in residents not being treated in a dignified manner.</p> <p>Findings include:</p> <p>Resident #33 was readmitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, Type 2 diabetes mellitus with diabetic neuropathy, and chronic obstructive pulmonary disease.</p> <p>Progress note dated August 9, 2023 indicated resident #33 neuro was alert and oriented x3 and psych was calm cooperative.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) of 15. The MDS also indicated the resident did not have any behavior or mood issues. The assessment also revealed that resident #33 needed substantial/maximal assistance with toileting.</p> <p>The facility 5-day investigation report dated August 11, 2023 revealed on August 11, 2023, resident #33 was upset and indicated a Certified Nursing Assistant (CNA) staff #313 was very mean to the resident. Resident #33 reported her call light was turned off by the CNA staff #313 and care had not been provided. Resident reported she was upset to the CNA staff #313. CNA informed resident that she was unable to wake resident. Resident and CNA started arguing per report and while resident #33 was speaking CNA staff #313 put her hand up to shoo the resident. Resident #33 reported that the CNA did not respect her. CNA #313 stated to resident you better watch your tone as I did nothing wrong and further stated to the resident you better respect me as your CNA because I am trying to help you. The report further indicated that CNA staff #313 got another CNA staff #507 to help her with the care of the resident but would not allow CNA #507 to take over the care of resident.</p> <p>In a handwritten statement by CNA staff #313, dated August 11, 2023 she reported she asked resident #33 to watch her tone because she did nothing wrong to resident. CNA staff #313 indicated she got another CNA staff #507 to be a witness while she changed the resident to avoid any allegations.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employee file contained a Corrective Action Form for CNA staff #313 dated August 16, 2023 regarding the incident on August 10, 2023. The form described the incident which indicated while producing care to a resident, CNA #313 rudely told the resident #33 to stop talking while the resident was expressing her concern for the delayed care. The form was signed by the DON and CNA staff #313.</p> <p>During a telephone interview with CNA staff #313 on December 31, 2023, she stated resident put call light on and when she went to the room, the resident was asleep and she was unable to wake the resident so she turned the call light off. CNA staff #313 stated a few hours later call light was back on and resident was angry and yelling. CNA informed resident she tried waking her but that resident not easy to wake due to loud CPAP machine. CNA also stated that resident had a history of behaviors but there was no documentation in the clinical record that resident had any behavior issues.</p> <p>Call placed to witness, CNA staff #507. CNA staff #507 stated that CNA staff #313 asked for help with resident #33 as the resident had a bad attitude. CNA staff #507 stated she tried to be a buffer between resident #33 and CNA staff #313 as the two kept bickering. CNA staff # 507 offered to take over care for the resident as she was tired of listening to CNA staff #313 and Resident #33 [NAME] but CNA staff #313 stated no that she would finish with the resident as it was her resident.</p> <p>Attempts were made to LPN staff #17, who was also present during the incident, left voicemail on both December 31, 2024 and January 2, 2025 but did not receive a call back.</p> <p>During an interview with the director of nursing (DON/staff #122) conducted on January 2, 2025, she stated staff are to complete training on dignity and respect upon hire and annually. DON stated it is her expectation that staff are not rude to a resident and if that should occur, she would expect another staff member to take over the care of that resident. DON stated she was familiar with Resident #33 and that she was a lovely lady. DON also stated resident #33 was very anxious and the incident would not have been good for the resident's health. DON also stated CNA staff #313 had a lot of attitude concerns and that CNA staff #313 has been written up for past incidents with the last one being May 28, 2024 for being insubordinate to supervisors.</p> <p>The facility policy titled Resident Rights revised September 10, 2024 stated that the resident has a right to a dignified existence and the resident has the right to be treated with respect and dignity.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006</p> <p>Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure that one resident (resident #47) was free from verbal abuse from an employee. The deficient practice could result in further instances of verbal abuse from an employee, creating an unsafe resident environment.</p> <p>Findings include:</p> <p>-Resident # 47 was admitted on [DATE] with a diagnosis of encounter for orthopedic aftercare following surgical amputation, anxiety disorder, muscle weakness, cognitive communication deficit, bipolar disorder, depression and was discharged on [DATE].</p> <p>A five-day admission MDS (minimum data set) dated December 28, 2022 revealed a BIMS (Brief Interview for Mental Status) score of 10, indicating that Resident #47 had moderate cognitive impairment. The MDS also revealed that the resident required maximal assistance to complete lower body dressing and putting on/taking off footwear. Indicating that a helper does more than half of the effort, assisting with lifts or holds trunk or limbs.</p> <p>Resident #47's progress notes revealed no evidence of documentation regarding the incident that occurred on January 1, 2023 at approximately 6:55PM.</p> <p>An interview was conducted on December 31, 2024 at 8:27AM an accounting clerk (Staff #25) where the personnel record of the perpetrator (previous employed certified nursing assistant/CNA/Staff #510) was reviewed. The review revealed two employee statements completed by the perpetrator dated November 8, 2022 and November 9, 2022, a corrective action form of a 2nd written warning with the date of November 10, 2022, an incomplete employee statement regarding the perpetrator's behavior dated December 30, 2022, and, a personnel action form of voluntary termination dated January 10, 2023 with an employee statement from the perpetrator. It was determined with Staff #25 that there was no documentation of a corrective action form of a 1st written warning, and as well as no other documentation of the incomplete employee statement dated December 30, 2022 regarding inappropriate behavior of the perpetrator.</p> <p>A review of CNA/Staff #510's corrective action form of a 2nd written warning dated November 10, 2022 revealed that the CNA/Staff #510 continued to refuse their assignments verbally stated that she was not going to do the new room assignments and walked away from the station. The form also revealed that CNA/Staff #510 made her co-workers feel intimidated and uncomfortable to work with.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on December 31, 2024 at 9:49AM with a previous employed licensed practical nurse (LPN/Staff #508), where LPN/Staff #508 stated that the perpetrator could be very inappropriate and required consistent re-direction with their language with staff and residents. She also stated that the perpetrator (LPN/Staff #508) was observed with intimidating behavior. During this interview, LPN/Staff #508 did require additional assistance with the incident details, to which this surveyor read their witness statement. Following this review, LPN/Staff #508 stated that they could re-call the incident but remembers that a CNA (/Staff #509) came to them with the allegation of verbal abuse from the perpetrator to resident #47. LPN/Staff #508 stated that the perpetrator could have said, when I tell you to put your mother****ing feet up, you get your mother ****ing feet up, and if not those exact words, then worse. LPN/Staff #508 also stated that they were concerned for retaliation due to the intimidating and taunting behavior of the perpetrator, following this incident.</p> <p>A phone interview with the alleged CNA (Staff #510) on January 2, 2025 at 8:55AM but was unsuccessful as she did call back at 8:59AM and quickly disconnected the call after this surveyor introduced themselves. An attempt to call back was made immediately after with no response or call back.</p> <p>A phone interview with a CNA who completed a statement in the facility's investigation (Staff #21) was attempted on January 2, 2025 at 9:10AM but was unsuccessful as she did not respond or call back.</p> <p>An interview was conducted with an LPN (Staff #39) on January 2, 2025 at 9:57AM, where staff #39 stated that they could recollect the perpetrator to have a 'bad' attitude. Staff #39 stated an example where she and the perpetrator had a disagreement regarding CNA assignments, which resulted into the perpetrator having to go home due to refusing to work that assignment. Staff #39 also stated that the perpetrator was not approachable and was not kind to other staff members, that at one point, they were put on separate shifts to limit their interactions. Staff #39 stated that they did not observe any behaviors with residents, however, has heard of inappropriate interactions with residents from other staff.</p> <p>An interview with the director of nursing (DON/ Staff # 122) was conducted on January 2, 2025 at 9:57AM where the shared their understanding of verbal abuse as telling someone they can't have something that is theirs, yelling and cussing at a resident, and providing inappropriate and rude customer service to residents. During this interview, a review of the incident report was done with the surveyor and Staff #122. Following this review, Staff #122 stated that their involvement with the reporting process does not extend into the investigation, but were familiar of the incident between the perpetrator and resident #47. Staff #122 stated that they were unaware of any behaviors regarding the perpetrator, however, did state that if an employee were to say, when I tell you to put your mother****ing feet up, you get your mother ****ing feet up, then that is verbal abuse, without a doubt.</p> <p>A policy titled, Abuse - identification of types revealed that examples of verbal abuse include but are not limited to harassing a resident, mocking, insulting, ridiculing, yellowing or hovering over a resident, with the intent to intimidate, and, threatening or isolating residents.</p> <p>A policy titled, Abuse - prevention, revealed the facility will identify, correct and intervene in situations in which abuse, neglect, exploitation and/or misappropriation of resident property, and that will include having trained and qualified (registered, licensed, and certified) staff on each shift in sufficient numbers to meet the needs of the residents. The policy also revealed that assigned staff will have the knowledge of the individual residents' care needs and behavioral symptoms, if any.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>51103</p> <p>Based on clinical record review, interviews, facility documentation and policies and procedures, the facility failed to ensure that one resident (#39) was free from physical and emotional abuse by another resident (#41). This deficient practice can create an unsafe environment for residents. The sample size was four residents.</p> <p>Findings include:</p> <p>Resident # 39 was admitted to the facility February 28, 2023 with diagnoses that included a traumatic brain injury, aphasia, epilepsy, mixed receptive-expressive disorder, and dependence of wheelchair.</p> <p>A quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident scored a 3 on the Staff Assessment for Mental Status, indicating the resident cognition is severely impaired. The resident is coded as having no behavioral issues directed towards others.</p> <p>A care plan goal of not harming self or others with the revision date of August 3, 2024 encourages the staff to analyze and document triggers, and what de-escalates harmful behavior. In addition, a care plan goal of not harming another resident, instructs staff to watch for signs of aggressive behaviors or resident flailing arms and to intervene as necessary.</p> <p>A progress note dated February 8, 2023 revealed the responsible party of the resident was notified, and was aware of the behaviors the resident normally exhibits.</p> <p>A progress note dated February 8, 2023 revealed the Director of Nursing (DON/Staff # 122) spoke with resident # 41 and documented the response he did not see anyone to help him with the other resident to have him stop moving the table.</p> <p>Resident was observed December 31, 2024 at 9:30 a.m. in his electric wheelchair in his room, moving arms about and pointing. Resident is non-verbal. The surveyor left to go get a staff member to assist with the resident.</p> <p>Regarding Resident # 41:</p> <p>Resident # 41 was readmitted to the facility September 16, 2024 with diagnoses that included a history of stroke with residual deficits, type 2 diabetes, muscle weakness, dementia with behavioral disturbance and depression.</p> <p>The annual MDS dated [DATE] revealed the resident had a Brief Interview Mental Status (BIMS) score of 13, which suggested the resident is cognitively intact.</p> <p>The care plan does not reflect any revision of behavioral disturbance goals or interventions between November 22, 2022 to October 31, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on December 31, 2024 at approximately 9:37 a.m. with resident #8. The resident stated that arguments occur often between residents because the response of management is always I'll have a talk with them about it. The resident is disheartened because nothing ever becomes of it, so residents take matters into their own hands. The resident stated it's hard to even relax in your room, when other residents are allowed to barge right in, without any consequence. The resident feels a lot of bad behaviors are excused by staff due to the offending resident's mental health problems, but feels it is unfair to the residents that follow the rules. The resident reports recently having to break up an altercation on Thanksgiving in the dining area during family visitation. The resident stated they were calling for help and but staff was not available to diffuse the situation, so he pulled his wheelchair between the arguing residents and was able to de-escalate the situation.</p> <p>An interview was conducted on December 31, 2024 at 10:45 a.m. with resident # 11. The resident revealed witnessing several verbal arguments between residents, and feels these occurrences are becoming more commonplace. The resident attributes part of the increase is due to a few residents with repeated bad behaviors are able to get away with making other residents feel stressed out. A recent example witnessed by the resident occurred on November 28, 2024 on Thanksgiving. The resident witnessed resident # 3 being threatened by another resident (unidentified) by stating he was going to kick his a---. No staff was in sight, so the incident was broken up by resident # 8 by parking his electric wheelchair between the two before it became physical. The resident recalled other residents calling for the staff as well, and was surprised with the loud radio, and shouting, no staff member came quickly to check on the commotion.</p> <p>A written interview/correspondence was received on December 31, 2024 at 12:41 p.m. with the Executive Director (ED/Staff # 505). The correspondence revealed the facility had no record of an incident on November 28, 2024 in the ballroom.</p> <p>An interview was conducted on January 1, 2024 at 9:37 a.m. with resident # 41. Resident # 41 recalls the incident and feels he tried to handle the situation the right way but he was not able to get any assistance from the staff so the resident handled the incident himself. Resident # 41 stated they were in the unit day room and states resident # 39 kept repeatedly hitting the table and trays and moving the table. Resident # 41 stated that resident # 39 always exhibits restless behaviors, and it always takes the staff over 30 minutes to even address all that constant banging. Some of us residents don't always want to deal with this, it is the staff's job not ours to keep an eye on him. The resident further continued and feels that staff should be supervising the dining area and day areas. The resident recalls he and others were calling out for assistance to handle the disturbance, but it was to no immediate avail. The resident stated hitting resident's # 39 hand, because verbal request did not work. The resident states he was not trying to cause major injury to resident #39, but rather to stop and correct the resident's behavior. The resident revealed he used the backscratcher because he could not reach the resident. The resident now describes the situation as water under the bridge since it has been a while, but they still let resident #41 continue to make a lot of noise all day.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on January 2, 2025 at 11:33 a.m. with Certified Nurse Assistant (CNA/Staff # 101). The CNA revealed the process if a resident gets into an altercation with another resident is to immediately separate them, alert the nurse, and then let the nurse take over the situation. In addition, during meals it is usually the CNA's or management who are assigned to monitor the dining area. The CNA clarified that there is not a designated nurse assistant to cover the unit dining area, it is whoever is available.</p> <p>An interview was conducted on January 2, 2025 at approximately 11:41 a.m. with a Licensed Practical Nurse (LPN/Staff # 39), who stated when two residents get into an altercation, they separate them and check for injurie. In addition, the staff will contact the providers, and facility management for further direction. Staff # 39 identified signs to prevent an incident from escalating. Those signs include monitoring a resident agitation, moods, abnormal movement. If an incident is escalating they immediately separate to diffuse the situation. Distraction is also a technique used to de-escalate a situation. In regards to monitoring the unit dining area, the CNA's or management team are usually supervising the residents while in there.</p> <p>An interview was conducted on January 2, 2025 at approximately 1:00 p.m. with the Ombudsman (Staff # 515). She stated the November 28, 2024 dining room incident was never brought to her attention, however she works with many residents who feel the need to take matters into their own hands.</p> <p>An interview was conducted on January 2,2025 at 12:33 p.m. with the Director of Nursing (DON/Staff # 122). The DON does recall the altercation between resident # 39 and resident # 41 and stated one of the residents was pushing around the table, he didn't see anyone to help him stop the resident so he used his backscratcher to get the other resident to stop. The DON continued that the steps that were taken so the behavior is not repeated was to remove the two residents away from each other, and restrict them from being in the same area together. The DON voiced awareness that the two residents were not moved and remained together on the same ward. The DON stated the rationale involved both resident's level of care. Both parties need assistance to be lifted into the wheelchair, so staff supervision is available. They are also confident that there will be no further issues, because the dayroom is a closely monitored area that sits in close proximity to the nurse's station. The DON stated people are in and out of there all the time, and the staff can see inside the day room. In regards to the dining room area, she states managers are assigned certain days to monitor the residents.</p> <p>An interview was conducted with the Executive Director (ED/Staff # 505) on January 2, 2025 at 1:12 p.m. The ED recalled receiving a phone call that a CNA saw resident # 41 waving his backscratcher at resident # 39. The ED stated they contacted the physician, family, and police, who conducted the investigation. The ED stated resident # 41 told the ED that he did not hit him but was using the backscratcher to wave the resident away. The ED reported that the resident # 39 was evaluated and there was no evidence of injury. The ED stated the steps that were taken to reduce the risk of this occurring again involved counseling resident # 41 to keep his distance from resident #39. In addition, resident # 41 now eats his meals in the dining room, instead of the day room. And lastly, due to resident level of care, the staff checks to make sure other residents are not within reach of resident # 39. The ED stated that both residents reside on the same ward, because neither party wanted to move rooms.</p> <p>The facility's Abuse- Identification of types identified corporal punishment (i.e. pinching, slapping of hands, or hitting with an object) is used to correct or control behavior.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103</p> <p>Based on clinical record reviews, interviews, facility documentation and policies, the facility failed to ensure that three residents (# 3, # 8, # 11) received consistent showers. The sample size was four residents. The deficient practice can result in resident grooming and hygiene needs not being met.</p> <p>Findings include,</p> <p>Regarding Resident # 3:</p> <p>Resident # 3 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation, dysphagia, morbid obesity, and chronic pain syndrome.</p> <p>A care plan with the revision date of October 5, 2023 revealed the resident's preference to not have a male assist with shower or baths.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 14 indicating the resident is cognitively intact. The MDS also indicated the resident has complete dependence for showers and shower transfers.</p> <p>A Weekly Skin Integrity Data assessment dated [DATE] indicated the resident had a rash on the arms and groin.</p> <p>A progress note dated June 9, 2024 revealed resident refusal of a shower and was advised that another shower would not be offered until his next shower day.</p> <p>A progress note dated June 13, 2024 revealed the resident requested a day time shower, but it was explained to him that he would be showered this evening. The resident also requested to have a female Certified Nurse Assistant (CNA) shower him, and declined the offer for a shower with the male CNA twice.</p> <p>A progress note dated August 6, 2024 revealed the resident was educated regarding his refusal of a shower.</p> <p>The interventions and task reports for May 2024 through December 2024 provided by the facility revealed the resident bath days were Saturday and Wednesdays. Based on the documentation received by the facility, the following was revealed:</p> <ul style="list-style-type: none"> - May 2024, 8 of 9 ordered bi-weekly showers were missed. -June 2024, 8 of 9 ordered bi-weekly showers were missed. -July 2024, 9 of 9 ordered bi-weekly showers were missed. -August 2024, 6 of 9 ordered bi-weekly showers were missed. <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-September 2024, 1 of 7 ordered bi-weekly showers were missed.</p> <p>-October 2024 ,3 of 9 ordered bi-weekly showers were missed.</p> <p>-November 2024 ,2 of 9 ordered bi-weekly showers were missed.</p> <p>-December 2024, 3 of 8 ordered bi-weekly showers were missed.</p> <p>Regarding Resident # 8</p> <p>Resident # 8 was admitted to the facility on [DATE], with diagnoses that included paralysis of dominant side after a stroke, lupus, morbid obesity, diabetes, congestive heart failure, and muscle weakness.</p> <p>The quarterly MDS dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 14, which indicated resident was cognitively intact. The MDS also indicated the resident required supervision or touching assistance for showers/bathing.</p> <p>A care plan with the revision date of December 20, 2024, revealed the resident required extensive assistance by one staff member while showering.</p> <p>A progress note dated August 9, 2024, revealed the resident was educated about refusing showers.</p> <p>A progress note dated January 6, 2023 revealed the resident required an anti-fungal powder to be applied to the resolving rash in the skin folds after showers.</p> <p>The interventions and task reports for May 2024 through December 2024 provided by the facility revealed the resident bath days were Tuesdays and Fridays. The documentation revealed the following:</p> <p>-May 2024, 4 of 9 ordered bi-weekly showers were missed.</p> <p>-June 2024, 6 of 8 ordered bi-weekly showers were missed.</p> <p>-July 2024, 6 of 9 ordered bi-weekly showers were missed.</p> <p>-August 2024, 6 of 9 ordered bi-weekly showers were missed.</p> <p>-September 2024, 2 of 8 ordered bi-weekly showers were missed.</p> <p>-October 2024, 7 of 9 ordered bi-weekly showers were missed.</p> <p>-November 2024, 1 of 9 ordered bi-weekly showers were missed.</p> <p>-December 2024, 8 of 9 ordered bi-weekly showers were missed.</p> <p>Regarding Resident # 11,</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER MI Casa Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 330 South Pinnule Circle Mesa, AZ 85206	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident # 11 was readmitted to the facility on [DATE] (original admitted [DATE]) with diagnoses that included an enlarged heart, leukemia, muscle weakness, depression, anxiety and morbid obesity.</p> <p>The quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact. The assessment also indicates the resident needs partial/moderate assistance with showering/bathing.</p> <p>A care plan with the revision date of October 21, 2024 revealed the resident required assistance of one staff member with bathing/showering.</p> <p>The interventions and task reports for May 2024 -through June 2024 and September 2024 through December 2024 provided by the facility revealed the resident bath days were Mondays and Thursdays. The documentation revealed the following:</p> <ul style="list-style-type: none"> -May 2024, 7 of 9 ordered bi-weekly showers were missed. -June 2024, 8 of 8 ordered bi-weekly showers were missed. -September 2024, 3 of 5 ordered bi-weekly showers were missed. -October 2024, 3 of 8 ordered bi-weekly showers were missed. -November 2024, 4 of 8 ordered bi-weekly showers were missed. -December 2024, 7 of 9 ordered bi-weekly showers were missed <p>Regarding Facility,</p> <p>The Quality Assessment and Assurance Meeting Agenda and Minutes dated August 17, 2023, revealed the facility needed a personal improvement plan for showers.</p> <p>The resident council meeting minutes dated February 28, 2024 revealed the Executive Director (ED/Staff # 505) discussed the facility doing their best to keep up with the shower schedule.</p> <p>The resident council meeting minutes dated May 9, 2024 revealed the concern of not receiving showers.</p> <p>A staff schedule /assignment sheet dated June 11, 2024 has written towards the bottom All Showers on NOC need to be done per [NAME] your DON.</p> <p>A staff schedule/assignment sheet dated June 12, 2024 has written towards the bottom All Showers are to be done per [NAME] your DON.</p> <p>The resident council meeting minutes dated June 13, 2024 revealed that a meeting for the Certified Nurse Assistants (CNA) was held to remind them to do their showers as scheduled.</p> <p>The resident council meeting minutes dated July 10, 2024 revealed the residents' outcry of No showers!!!</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on December 30, 2024 at approximately 12:30 p.m. with the Ombudsman (Staff # 515). The Ombudsman stated there has been an issue with residents not receiving showers for months, and states this is often a topic of concern at resident council meetings as well. She further explained when these matters are brought to the attention of management, but has yet to see any plan implemented or successful resolution.</p> <p>An interview was conducted on December 31, 2024 at 9:37 a.m. with resident # 8. The resident would like to see more staff on the floor that answer call lights, and give showers as they should. The resident feels there is not enough staff to provide the right amount of care for the residents. The resident states when in resident council they continually bring up the issue of showers not being completed, and becomes disappointed when there is no change. Resident also reported that he was not receiving showers on the night shift so he has been making request to start day shift showers.</p> <p>An interview was conducted on December 31, 2024 at approximately 10:20 a.m. with resident #3. The resident revealed there is much improvement needed in the performance of the care aides and completing showers. The resident stated he is supposed to get 2 showers a week, but it hardly gets done because they only have one person doing the showers</p> <p>An interview was conducted on December 31, 2024 at approximately 10:45 a.m. with resident # 11. The resident revealed that they go long stretches, once as long as two weeks, without receiving a shower. The resident continued to voice that when the staff were not helping keep her skin folds clean and dry, they allowed the yeast rash to return. In addition, poor call light response the resident has experienced sitting in wet brief for hours on many occasions, which also contributed to the yeast rash returning.</p> <p>An interview was conducted on January 1, 2025 at 9:20 a.m. with Certified Nursing Assistant (CNA/Staff # 36). The CNA stated that nurse assistants are responsible for reporting to the nurses any abnormal skin findings detected during resident brief changes and showers.</p> <p>An interview was conducted on January 2, 2025 at 9:28 a.m. with the Infection Preventionist (IP/Staff # 261). The IP explained ways to reduce chances of developing a yeast skin infection, which included; ensuring the resident is clean and dry and making sure areas prone to sweat are kept clean and dry.</p> <p>An interview was conducted on January 2, 2025 at 9:38 a.m. with the Director of Nursing (DON/Staff # 122). The DON revealed the CNA's are required to document showers/baths/and refusals in the clinical record.</p> <p>An interview was conducted on January 2, 2025 at 10:49 a.m. with the Wound Care Nurse (WCN/Staff # 56). The WCN stated that risk factors such as heavier set people with skin folds, can be hard to stay dry. For a resident with a chronic yeast skin infection, showering and keeping the resident dry helps the resident not have a rash exacerbation. Furthermore, if those interventions do not resolve the issue, they contact the provider for further guidance, which typically includes the use of antifungals.</p> <p>The facility policy Activities of Daily Living dictates the facility must provide ca and services for resident hygiene, which included bathing and dressing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Resident Rights indicates the resident has the right to receive services in the facility with reasonable accommodations and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>The facility policy Staffing dictates the facility maintain adequate staff on each shift to meet the needs of the residents.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on clinical record review, staff interviews, facility documentation, and review of facility policy and facility assessment, the facility failed to ensure it had adequate staffing to meet the needs of the residents.</p> <p>Review of Resident Council meeting minutes revealed the following staffing related concerns:</p> <ul style="list-style-type: none"> -March 02, 2023: The Director of Nursing (DON / Staff #122) spoke to residents about staffing and the efforts to hire more staff. -October 05, 2023: concerns with Saturday and Sunday staffing -January 04, 2024: concerns with call lights being turned off only after the Residents' needs/wants are met. -February 08, 2024: Discussion of business with executive director (ED / Staff #505): regarding call lights, staff could forget. Put the call light back on, and Doing the best we can to keep up with shower schedule. -March 14, 2024: a resident discussed with the ED earlier in the day about concerns discussed in last month's resident council meeting, which she learned have not been addressed, by neither the ED nor the DON. -May 09, 2024: Old business discussed on March, 2024 still unresolved. New concerns included no showers, short staffed, no staff on weekends, staff idle at the nurse's station. Additionally, one resident reported he cannot get a hold of anyone, when he has difficulty breathing. Another resident was revealed to state that night shift took too long to change and put back to bed. <p>Review of the facility's Grievance Log and Concern and Comment Forms revealed:</p> <ul style="list-style-type: none"> -January 09, 2023: a resident revealed that one time she waited over an hour to have someone help her off the bedside commode, and that she had to call the front desk. -February 08, 2023: a resident revealed that her call light was on from 8:00 PM to 10:30 PM, when she was given her night time medications that should have been given at 8:00 PM. The Investigation Findings on the form revealed that an In-Service was given for staff to monitor call lights closely. <p>Direct Care Staffing was reviewed via the daily staff posting, staff schedule, and staff punch logs, for the date of March 16, 2023, and revealed the following staff for the whole facility. The census for that day was 116 residents.</p> <p>Day:</p> <ul style="list-style-type: none"> -Registered Nurses (RN): 3 <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Licensed Practical Nurses (LPN): 2</p> <p>-Certified Nursing Assistants (CNA): 4</p> <p>Evenings:</p> <p>-CNA: 6</p> <p>Nights:</p> <p>-RN: 1</p> <p>-LPN: 4</p> <p>-CNA: 6</p> <p>An observation was conducted on December 30, 2024, on the 300 hall unit. At 1:19 AM, a call light was observed to be on for room [ROOM NUMBER]. A nurse was observed at the nurse's station, and was working at a computer. There were no care staff observed on the floor.</p> <p>The observation continued, and at 1:30 PM, a staff member entered the hall, and wheeled a different resident from another room out of the hallway in a wheelchair. The call light for room [ROOM NUMBER] was still unanswered.</p> <p>The observation continued. At 1:48 PM, the call light was still unanswered. The floor nurse was observed to tell a nurse from a different hallway that he is going on break, and then he left the unit.</p> <p>At 1:49 PM, a male resident was observed on the unit yelling for help and stated she's in my room and eating my stuff. The DON was on the unit at the nurse's station, and responded to the resident yelling for help. The DON was observed to take a female resident who was in a wheelchair out of the male's room, and the DON then wheeled the female resident in the wheelchair off the unit. The call light for room [ROOM NUMBER] was still unanswered. Besides a housekeeper, there were no other staff observed on the unit.</p> <p>The observation continued, and at 1:54 PM, a CNA was observed to enter the unit and responded to the call light for room [ROOM NUMBER]. The call light was turned off, and the CNA exited the room. The time that the call light was observed to be on was 35 minutes.</p> <p>After the CNA left room [ROOM NUMBER], a follow-up interview was conducted at 1:56 PM, with the resident in that room. The resident in bed A stated that he said he needed to be changed, and that the staff member stated that she would be back. He further stated that sometimes it feels like they don't care at all. He stated that at night it is really bad, that the CNAs won't answer your call light for 45 minutes to an hour. He stated he hears the staff joking around in the hallway at night.</p> <p>The observation continued, and at 2:41 PM, the nurse returned to the unit from his break. The time that the nurse was observed to be off of the unit was 53 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An additional observation was conducted on the 400 hall on December 31, 2024, at 10:15 AM. Two call lights were observed to be on in rooms [ROOM NUMBERS]. The ED (Staff #505) entered the unit and responded to one of the rooms with the call light on. The DON (Staff #122) entered the unit at 10:44 AM, and entered room [ROOM NUMBER], with the call light still on, and exited the room at 10:45 AM, with the call light still on.</p> <p>At this time, an interview was conducted with the resident in room [ROOM NUMBER]. The resident stated that his call light had been on for awhile, and that staff had just come in and said they would get a CNA because he needed to be changed. The surveyor then left the room.</p> <p>The observation continued from the hallway, and at 10:48 AM, a CNA entered room [ROOM NUMBER], and the call light was turned off. The call light for room [ROOM NUMBER] was observed to be on for 33 minutes.</p> <p>An interview was conducted with a member of the Resident Council on January 2, 2025, at 11:24 AM. The resident stated that staffing and long call light wait times had been a repeated concern discussed during meetings since she had been a member of Resident Council. She stated that I think we all have had to wait, for more than 30 minutes. She stated that a couple times, I've noticed 45 minutes.</p> <p>An interview was conducted with the DON on January 2, 2025, at 11:34 AM. The DON stated that her expectation for staff taking a break during their shift would be a half hour, and that if a staff took longer than 40 minutes, she would consider that too much. The DON stated that in regard to call light wait times, that she considered 20 to 30 minutes too long. She stated that there has been an issue with finding staff, and that it has been ongoing. She stated that staffing requirements for the facility for the year of 2023 was 2 nurses every shift for station 1 and 2, and 1 nurse for station 3 every shift. For CNAs, the facility required 2 CNAs for station 1 every shift, and station 2 would have 3 to 4 CNAs for every shift, and that station 3 would have 2 CNAs every shift. She clarified that this was for census over the number of 104 residents. The staffing schedule for March 16, 2023, was reviewed with the DON, who stated that staffing would not meet her expectation, that she would consider it short-staffed, and that she would want more staff. The DON stated that the risks to residents of understaffing would be falls, skin issues, and residents not having the total care that they need to have.</p> <p>An interview was conducted with the Staffing Coordinator (Staff #180). The staffing data for March 15 and 16, 2023, was reviewed together with Staff #180. who stated that 6 CNAs to cover the whole building for a shift would not meet the staffing requirements. She stated during that timeframe, the care was not at the level it should have been, and that we are still a little understaffed, but that it has improved.</p> <p>The ED stated that there was no staffing policy, and that the Facility Assessment was used to guide staffing.</p> <p>Review of the Facility Assessment, revised June 24, 2024, revealed the average daily census was 104 to 117 residents. The Direct Care Staffing needs were as follows:</p> <p>Station 1 Day:</p> <p>-Registered Nurses (RN):0-2</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on the clinical record review, staff interviews, facility document, and quality assessment and assurance meeting minutes, the facility failed to ensure it had adequate staffing on August 22, 2023.</p> <p>An interview with the Staffing Coordinator #180 December 31, 2023 10:41 am, she stated that staffing is based on the resident census and acuity for each station. The Facility has three stations with Station 1 as the skilled unit. She added, ideally there should be at least two (2) licensed nurses in each station and shifts or six (6) licensed nurses per day while three to four (3-4) CNAs per station and shifts or ten to eleven (10-11) CNAs per day. This is based on the facility's staff assessment.</p> <p>On the night of September 22, 2023 the facility was understaffed especially with the CNAs on the evening and the night shifts. Moreover, only one CNA covered the twenty eight (28) residents at station 3 that night and the same CNA continued to work the night shift at the same station. Overall, on September 22, 2023 there were insufficient numbers of CNAs to cater for the needs of the residents in all the stations and shifts.</p> <p>The Staffing Coordinator #180 stated that the facility is struggling with hiring sufficient numbers of CNAs despite efforts to hire more staff. She stated that there is a high turnover for CNAs with high rates of attendance issues. She reported that these staffing issues were brought up to the leadership team and currently the facility is working on solutions to address these problems.</p> <p>In an interview with CNA #54 on December 31, 2024 12:30 am stated that currently there are three CNAs that work during the day shift with sometimes four CNAs, depending on the availability of staff. The CNA #54 stated that one of the reasons for low staff was the change of the shift hours from eight (8) to twelve(12) hour shifts. She stated that a lot of CNAs resigned because they did not want to work 12 hours. Further, CNA #54 said the new staffing coordinator would not work with the CNAs regarding the 12 hour shifts, so those CNAs resigned. She also added that some day shifts have 4 CNAs tending to fifty four (54) residents. However, the CNA #54 is adamant that more CNAs are needed but they are working with the team at this time to meet the goals of the residents.</p> <p>During an interview with the Director of Nurse (DON) #122, the DON mentioned that the ripple effects of COVID-19 had a direct impact on care staff up to 2023. The DON understood the fact that it was hard at the time to hire sufficient numbers of nurses including CNAs. The DON revealed that the evening shifts are the hardest to fill, however it has improved lately. The DON understood the needs to improve the ongoing staffing specifically on the night of September 22, 2023, and related that not meeting the staffing requirement posed risks to the residents' health outcomes such as falls, skin issues, and not having the care they need. The DON stated that the staff had brought this to their attention and are currently trying to hire more staff to meet the needs of the residents.</p> <p>The facility has no staffing policy, however the facility assessment is used for staffing and they do not use the nursing registry at this time. Moreover, based on reviewing the quality assessment and assurance meeting agendas (QAPI) 2023, staffing issues were continuously raised as one of the facility's concerns. Although there was no incident reported from the station where the complainant worked on October 22, 2023, this intake was substantiated due to inadequate staffing.</p>		