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	09/05/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to accurately document wound treatment for one resident, which could cause a delay in required wound treatment, prolonging healing time, a possible infection, and needless pain to the resident. Findings include:Resident #42 was admitted on [DATE] with diagnoses that included encounter for surgical aftercare, type 2 diabetes, infection following procedure, acute respiratory failure with hypoxia, protein-calorie malnutrition, sepsis, atherosclerotic heart disease, muscle weakness, intestinal obstruction, hypothyroidism, hypertension, vascular disorder, gastro-esophageal reflux disease, depression, hyperlipidemia, insomnia, and absence of the right leg below the knee.A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS also revealed that the resident had surgical wounds and would receive surgical wound care, application of nonsurgical dressings, and application of ointments and medications other than to the feet.A wound progress note dated September 3, 2025, at 3:14 p.m. revealed that the resident was admitted with an abdominal surgical wound, and that the treatment had changed to Adaptic on biological mesh, acetic, then acid-soaked gauze, followed by a dry dressing, with the wound team to follow.An order initiated on September 3, 2025, at 3:20 p.m. for acetic acid irrigation solution 0.25% every shift for surgical wound care via irrigation and 1 use application was charted to have occurred on the day and night shift of September 3, 2025. The order specified to cleanse with normal saline (NS), pat dry, apply Adaptic (a non-adhering gauze dressing) on the biological mesh, lightly pack with the acetic acid-soaked gauze, and cover with a dry dressing. A care plan initiated on July 15, 2025, revealed an intervention to initiate and continue the care plan for abdominal wounds.An interview was conducted on September 5, 2025, at 12:22 p.m. with a Licensed Practical Nurse (LPN/Staff#25) who stated that she was familiar with Resident #42 and that she assisted with her wound care. The LPN stated that she was taken off the schedule because the facility told her she did not do Resident #42's wound care as it was ordered. The LPN stated that she did not do the wound care on the night shift of September 3, 2025, because it was so busy that night, and when she opened up the treatment administration record, she did not know there was a wound change. The LPN stated that she tried to tell the Director of Nursing (DON/Staff#58) that it was an honest omission because she did not intend to make the mistake, but that night it was already too late to do the wound care. The LPN stated that the order was to change the dressings twice a day on the day and night shifts, and that the day shift nurse told her that the wounds were already done. An interview was conducted on September 5, 2025, at 1:12 p.m. with the DON, Staff #58, who stated that she was familiar with a wound concern regarding Resident #42 and that she suspended the nurse involved immediately. The DON stated that she spoke with the resident on the morning of September 4, 2025, who revealed to her that the nurse did not do her wound on the evening of September 3, 2025. The DON also stated that they missed one wound treatment, but the resident's wound was bad, and the order was for dressing changes twice a day. The DON stated that the wound care did not happen according to the LPN (Staff #25) and Resident #42, but it was charted by the LPN that she did complete the wound care. The DON stated that it was not her expectation to see the LPN chart that she completed a treatment that she did not do because it made her question the nurse, and she would expect that if you did not, or could not complete a treatment, her staff should document why and chart properly. The DON stated that the risk of missing a wound treatment could be infection, having to have more surgery, or death, and the risks of inaccurately charting treatments in the medical record would be the same. A review of a policy titled, Nursing Documentation, was conducted on September 5, 2024, and revealed that the facility would ensure nursing documentation was consistent with professional standards of practice, the state nurse practice act, and any state laws governing the scope of nursing practice. The policy also revealed that the medical record would reflect a resident's progress toward achieving their person-centered plan of care objectives and goals and the improvement and maintenance of their clinical, functional, mental and psychosocial status. The policy also revealed that the medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatment and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions.