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	01/09/2026

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** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure that 1 of 2 sampled residents (Resident #1) was free from abuse by staff members (Staff #182, Staff #111, and Staff #174). The deficient practice could result in other residents being abused.Findings include:-Regarding Resident #1Resident #1 was admitted on [DATE], with diagnosis that include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified protein-calorie malnutrition, facial weakness following cerebral infarction, dysarthria following cerebral infarction, and dysarthria following cerebral infarction. A comprehensive care plan initiated on December 19. 2025 revealed that Resident #1 had a nutritional problem or potential nutritional problem related to gastric tube placement with history of dysphagia and unable to meet enteral nutrition with oral intakes.An Enteral feed order dated December 19, 2025 revealed that Resident #1 was to get Jevity every 4 hours 1.5 237 milliliters (mL) via bolus/gravity. Following the bolus, the Resident was to receive a flush of 50 mL purified water after feeding. A Health Status note dated December 20, 2025 from Registered Nurse (RN/Staff #2) revealed that Resident #1 received bolus of Jevity as ordered but Resident suffered from occasional confusion and can be resistive with cares refusing peg tube care. A Behavior Note dated December 21, 2025 from Licensed Practical Nurse (LPN/Staff #182) at 9:34 p.m., revealed that a bolus feeding was being given but resident was combative by pushing nurses hands away saying no more food and water. Staff #182 explained to Resident #1 the need for the water flush after a bolus feed and agreed to the flush of water. A Behavior Note dated December 22, 2025 from Staff #182 at 12:50 a.m. revealed that the midnight bolus feed given with assistance of CNA #111, and CNA #174. The note also revealed that resident was trying to kick staff and push food away so CNA # 174 and #111 held his hands and knees down while bolus feed was given while Resident #1 was saying no more food, no more water. A Behavior Noted dated December 22, 2025 from Staff #182 at 4:29 a.m. revealed that Resident #1 reported he did not want his food and bolus was not given. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview or Mental Status (BIMS) score of 14, indicating cognitively intact thinking and memory. The MDS also revealed that Resident #1 is dependent on staff for eating and has difficulty or pain with swallowing resulting in the use of a percutaneous endoscopic gastrostomy (PEG) tube. The MDS revealed that the resident had been known to reject cares. -Regarding Staff #182Review of Staff #182's (alleged perpetrator) personnel file revealed that she was employed as a Licensed Practical Nurse with a start date of September 16, 2020.Further Review of Staff #182's personnel record also revealed an employee training checklists, which included topic of Resident Rights and Elder Justice and abuse completed October 1, 2020 and again on March 13, 2021. A Corrective Action Form dated July 14,2022 revealed that a verbal warning was presented to Staff #182 for using profane language in hallway while working and became angry with a co-worker and began using cursing statements towards and about (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	the co-worker. A Suspension Pending Investigation Form dated December 22, 2025, revealed that Staff #182 was suspended without pay pending further investigation into assault allegations by Resident #1. A Personnel Action Form effective December 22, 2025 revealed that Staff #182 was terminated involuntarily for violation of rules and policies due to participation in resident abuse. A Termination Form dated December 24, 2025, revealed that Staff #182 was terminated due to participation in resident abuse. The termination form also revealed that Staff #182 forcefully administered treatment to a resident who was refusing the care provided. Staff #182 requested the assistance of other staff members and continued to provide treatment after the resident voiced his refusal of care. -Regarding Staff #111Review of Staff #111's (alleged perpetrator) personnel file revealed that she was employed as a CNA with a start date of March 21, 2025.Further Review of Staff #111's personnel record also revealed an employee training checklists, which included topic of Resident Rights and Elder Justice and abuse completed March 21, 2025 and April 9, 2025. A Suspension Pending Investigation Form dated December 22, 2025, revealed that Staff #111 was suspended without pay pending further investigation into assault allegations by Resident #1. A Personnel Action Form effective December 22, 2025 revealed that Staff #111 was terminated involuntarily for violation of rules and policies due to participation in resident abuse. A Termination Form dated December 24, 2025, revealed that Staff #111 was terminated due to participation in resident abuse. The termination form also revealed that Staff #111 admitted to holding Resident #1's left hand down so Staff #182 could continue to administer a tube feeding flush against the resident's wishes. -Regarding Staff #174Review of Staff #174's (alleged perpetrator) personnel file revealed that she was employed as a CNA with a start date of April 3, 2023.A Corrective Action Form dated March 25, 2025, revealed that a verbal warning was presented to Staff #174 for confronting another employee regarding missed assignments in a resident's room. An Associate Performance Review dated April16, 2025 revealed that Staff # 174 frequently exceeded expectations however she required education on respect in the workplace. A Suspension Pending Investigation Form dated December 22, 2025, revealed that Staff #174 was suspended without pay pending further investigation into assault allegations by Resident #1. A Personnel Action Form effective December 22, 2025 revealed that Staff #174 was terminated involuntarily for violation of rules and policies due to participation in resident abuse. A Termination Form dated December 24, 2025, revealed that Staff #174 was terminated due to participation in resident abuse. The termination form also revealed that Staff #174 admitted to holding the tube feed syringe for Staff #182 while she administered a water flush against the resident's wishes.The Facility Investigation report dated December 26, 2025, revealed that the facility verified the allegation of staff abuse to Resident #1 and terminated the employment of Staff #182, #111, and #174. An interview was conducted on January 9, 2026 at 12:03 p.m. with Resident #1 revealed that the resident refused multiple times by pushing the tube away and verbally saying he did not want the treatment. Resident #1 revealed that he did not want the flush afterwards because it caused him to go to the bathroom and when he tried to push it away the nurse brought more staff to hold me down while she flushed it against his wishes. An attempt was made to contact Staff # 182 on January 9, 2026 at 12:50 p.m., but he phone call was not returned by staff member. An attempt was made to contact Staff # 111 on January 9, 2026 at 12:53 p.m., but the phone call was not returned by staff member. An attempt was made to contact Staff #172 on January 9, 2025 at 12:55 p.m. but the phone call was not returned by staff member.An interview was conducted on January 9, 2026 at 1:22 p.m. with RN (Staff #2), via phone, revealed that she never had trouble giving Resident #1 flushes after his bolus but he did not like when I cleaned around the site. Staff #2 says that after the incident staff go in cares in pairs and his orders were changed away from bolus feeding and more continuous (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feeding which is working better. An interview was conducted on January 9, 2026 at 1:34 p.m. with CNA (Staff #120), revealed that she does not have any difficulty providing cares to Resident #1 when she is assigned to him. The CNA revealed that the CNA's do not typically work with tube feeding of a resident. CNA #120 also revealed that restraining a resident and ignoring a resident refusal is a form of abuse. An interview was conducted on January 9, 2026 at 1:49 p.m. with DON (Staff #164) who revealed that he expectation if a resident refuses any treatment that the staff would stop, notify her and physician and document. The DON revealed that initially Resident #1 entered the facility as bolus feed but he did not like being waken up at night and having to go to the bathroom which is why Resident #1 refused the tube flushes at night. The DON revealed that staff #182 felt that she needed to provide the flush of the tube no matter what the resident said. Since Resident #1 had fought Staff #184 on the tube feed, Staff #184 felt the need to bring in the CNAs in to help administer the midnight dose. The DON was unable to answer why RN #182 felt the need to initiate a midnight does knowing that the resident was going to refuse. The DON stated the actions of Staff 182, 111, and 174 did not meet here expectations and went against facility policy and they were terminated. A Policy and Procedure titled, Abuse Identification of Types, reviewed May 6, 2025, revealed that the resident has the right to be free from abuse including physical or chemical restraint not required to treat the resident's medical symptoms. A Policy and Procedure title, Resident Rights, revised September 10, 2024, revealed that the resident has the right to request, refuse, and or discontinue treatment.