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	03/18/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that the abuse policy was implemented following an incident involving staff-to-resident abuse and neglect for one resident (#70). The deficient practice could result in continued abuse, neglect, and physical or emotional harm to residents.Findings include:Resident #70 was admitted on [DATE], with diagnoses that included hemiplegia and hemiparesis, protein-calorie malnutrition, facial weakness, dysphagia, muscle weakness, aphasia following cerebral infarction, cognitive, social, or emotional deficit, frontal lobe and executive function deficit, atrial fibrillation, hydrocephalus, convulsions, and headache.An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS also revealed that the resident exhibited a behavior of rejecting care for 1-3 days. A care plan initiated on December 23, 2025, identified the resident at risk for alteration in psychosocial well-being due to staff failure to honor resident choices during care on December 22, 2025. The care plan revealed interventions to provide psychosocial support when in the patient's room by conversing with the resident or asking if they have questions, or trying to reduce fear, following care in pairs, and reporting changes in mental status or psychosocial changes to the physician as appropriate. The facility investigation file revealed a handwritten Concern & Comment Form completed by the Executive Director (ED/Staff#74) on December 27, 2025, at 1:50 p.m. The handwritten form revealed that the ?patient' stated he felt that he was being neglected by facility staff because he was left in a wet brief for a few hours, and the resident wanted the facility to call law enforcement for neglect. The handwritten form further revealed that the concern was reported to the ED, Staff #74, and that the staff member was able to resolve the concern at the time it was shared. The handwritten form also revealed a section titled Facility Investigation and Response, which revealed that the ED spoke with the resident and his wife at 1:50 p.m. on December 27, 2025, and they reported that the resident did not receive care upon arrival from the hospital. The handwritten form revealed that the investigation findings were concluded at 2:30 p.m. on December 27, 2025, and found that the patient did receive care throughout the night when he arrived, again at midnight, and lastly when the nurse checked on his feeding pump. The facility's actions were to remind staff to do care in pairs, and to shower the resident to make sure he was cleaned. The handwritten form also revealed that the patient was informed that the Registered Nurse (RN/Staff #46), would not be providing care for him, as requested. A telephonic interview was conducted on March 18, 2026, at 9:33 a.m. with Resident #70's wife, who stated that her husband was abused and neglected at the facility on the night of December 26, 2025, into December 27, 2025, and that she reported the allegation to the facility administration that day. Resident #70's wife stated that the night shift Registered Nurse (RN/Staff#46) and a Certified Nursing Assistant (CNA/Staff#13) responded to Resident #70's call light for a brief change after he spilled his bedside urinal on his leg, and that they turned him back and forth aggressively during the brief change. The resident's wife stated that the resident asked staff to stop, and that Staff #46 made a comment to the staff member who was assisting that they needed to get out of the room or else he would get them fired. The resident's wife further stated that staff ignored him for the rest of the night (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: 035120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and left his bed remote out of his reach. Resident #70's wife stated that there were two police reports filed regarding abuse and neglect during her husband's stay at the facility, one on December 22, 2025, and another on December 27, 2025. Resident #70's wife stated that the incident from December 27, 2025, was never reported by the facility to any state agency except the police, and that the ED, Staff #74, told her he was not going to report the incident because he did not deem it necessary. A telephonic interview was attempted on March 18, 2026, at 10:16 a.m. with a CNA, Staff #13, but was unsuccessful.A telephonic interview was conducted on March 18, 2026, at 10:19 a.m. with an RN, Staff #46, who stated that the timeframe for reporting abuse and neglect was right away to the administrator, and that she has never had anyone report or make an allegation of abuse, neglect, or rough care to her, or against her. The RN initially stated that she did not recall Resident #70, however, she later stated she could recall him. The RN stated that Resident #70 was very aggressive with staff, he refused care a lot, including care for his tube feeding, and she did not know if he had ever reported abuse or neglect. The RN further stated that Resident #70 did not like one of the CNA's, but she could not recall who, and she stated that the resident never asked her to stop during care. The RN stated that she heard that there was an incident with three staff members who were fired, and that the resident told her he did not like two of the staff members, one CNA, Staff #13, and a Licensed Practical Nurse (LPN/Staff#86), and that he did not want to see them again, which was reported to the previous Director of Nursing (Previous DON/Staff#82). The RN also stated that she did not ignore Resident #70, and that she did not make the statement that they needed to get out of the room or else he would get them fired. A telephonic interview was attempted on March 18, 2026, at 10:44 a.m. with the previous Director of Nursing (Previous DON/Staff#82), but was unsuccessful.A telephonic interview was conducted on March 18, 2026, at 11:31 a.m. with the ED, Staff #74, who stated that the timeframe for reporting allegations of abuse and neglect was right away for staff, but he needed to report to the Arizona Department of Health Services (AZDHS), Adult Protective Services (APS), the police, the ombudsman, the medical director, and the DON within one hour. The ED stated that, in the last four months, the facility has only had one self-report regarding Resident #70, that it had already been investigated, and that the date of the incident was December 22, 2025. The ED stated that on December 26, 2025, he completed the 5-day report for the previous incident, and that the incident on the 27th was not abuse. The ED stated that the resident was at the hospital on December 26, 2025, and that the wife of Resident #70 reported to him that the resident was neglected on December 27, 2025. The ED stated that he came into the facility over that weekend to talk to the resident's wife after the admissions staff called him to say that the wife of Resident #70 made an allegation of neglect for her husband. The ED further stated that he sat in his office with Resident #70's wife, and then he went to talk with the resident, who contradicted the wife's allegation of neglect. The ED also stated that if he had two statements, one person saying something happened, and another person saying the opposite happened, he would not report it. The ED stated that he reported the incident from December 22, 2025, because the nurse said the incident happened, but that he did not report the incident from December 27, 2025, to any state agency, and he initially stated that he did not call the police for the incident on December 27, 2025, however, he then stated that he did call the police because Resident #70's wife wanted to file a police report. The ED also stated that he told Resident #70's wife that he was not going to report it because the resident told him he was not being neglected, and that he took written statements from staff regarding the incident from the 27th. A telephonic interview was attempted on March 18, 2026, at 12:08 p.m. with Resident #70, but was unsuccessful.A telephonic interview was conducted on March 18, 2026, at 2:03 p.m. with an LPN, Staff #86, who stated that the timeframe for reporting allegations of abuse and neglect was as soon as possible to the DON, and that she could recall Resident #70. The LPN stated that the resident was not under her care, but she worked with him a few times because he made allegations against the RN, Staff #46, and that the previous DON, Staff #82, instructed the LPN to switch with the RN to prevent further escalation of the situation.A telephonic interview was conducted on March 18, 2026, at 2:12 (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. with a CNA, Staff #51. The CNA stated that she recalled Resident #70, and stated that the resident got three staff members fired for a prior incident. The CNA further stated that the resident was receiving two-person care at all times, she refused to go into his room because of his history of making allegations, but they were short-staffed on December 26, 2025, so she was asked by two CNAs, Staff #13 and Staff #10, on two different occasions that night to assist with two-person care. The CNA stated that the resident spilled his bedside urinal, they completed a full bed change, and she left the room until the last rounds of her shift at 5 a.m. on December 27, 2025. The CNA stated that the previous DON, Staff #82, called her later that same day because she was supposed to work again that afternoon, and told her not to come in because Resident #70 reported that the night shift had neglected care for him all night, and that they needed her to write a statement. The CNA also stated that she was not suspended, but that the facility needed her to wait to clock in until they investigated the allegation, and she worked again that night, around 6 p.m. The CNA stated that she did not speak with police about the incident, and that she had only spoken to the previous DON about it. The CNA also stated that the resident made allegations against the RN, Staff #46. A telephonic interview was conducted on March 18, 2026, at 2:31 p.m. with a CNA, Staff #10. The CNA stated that she recalled Resident #70, and that he never made an allegation of abuse or neglect. The CNA further stated that she was told to only give care to the resident in pairs with another staff member because he was having issues with staff and saying that no care was being given. The CNA stated that there was another incident with the resident before involving staff members being fired, and that after that incident, he reported that he was not getting care. The CNA stated that she would not check on the resident unless he pressed his call light because that was his preference, and that she was told that the wife of Resident #70 reported that they were neglecting him.Review of a policy titled, Abuse - Identification of Types, with a review date of May 6, 2025, revealed that abuse was defined as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy further revealed that abuse also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The policy also revealed that neglect was defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Review of a policy titled, Abuse - Reporting and Response - No Crime Suspected, with a review date of May 7, 2025, revealed that, in response to allegations of abuse and neglect, all alleged violations needed to be reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or no later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury to the administrator and to other officials, including the State Survey Agency and Adult Protective Services. The policy further revealed that an individual who reports an alleged violation would not have to explicitly characterize the situation as abuse or neglect to trigger a facility investigation; if staff could reasonably conclude that the potential exists, it would be considered reportable and required action. The policy also revealed that all alleged violations, whether oral or in writing, must be reported to the administrator of the facility and to other officials in accordance with State law through established procedures. The policy further revealed that the facility must provide sufficient information to describe the alleged violation and indicate how residents are being protected in its report, and within 5 working days of the incident, the facility must provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that an incident involving staff-to-resident abuse and neglect for one resident (#70) was reported to the required state agencies. The deficient practice could result in continued abuse, neglect, and physical or emotional harm to residents.Findings include:Resident #70 was admitted on [DATE], with diagnoses that included hemiplegia and hemiparesis, protein-calorie malnutrition, facial weakness, dysphagia, muscle weakness, aphasia following cerebral infarction, cognitive, social, or emotional deficit, frontal lobe and executive function deficit, atrial fibrillation, hydrocephalus, convulsions, and headache.An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS also revealed that the resident exhibited a behavior of rejecting care for 1-3 days. A care plan focus initiated on December 23, 2025, identified the resident at risk for alteration in psychosocial well-being due to staff failure to honor resident choices during care on December 22, 2025. The care plan revealed interventions to provide psychosocial support when in the patient's room by conversing with the resident or asking if they have questions, or trying to reduce fear, following care in pairs, and reporting changes in mental status or psychosocial changes to the physician as appropriate. The facility investigation file revealed a handwritten Concern & Comment Form completed by the Executive Director (ED/Staff#74) on December 27, 2025, at 1:50 p.m. The handwritten form revealed that the ?patient' stated that he felt that he was being neglected by facility staff because he was left in a wet brief for a few hours, and the resident wanted the facility to call law enforcement for neglect. The handwritten form further revealed that the concern was reported to the ED, Staff #74, and that the staff member was able to resolve the concern at the time it was shared. The handwritten form also revealed a section titled Facility Investigation and Response, which revealed that the ED spoke with the resident and his wife at 1:50 p.m. on December 27, 2025, and they reported that the resident did not receive care upon arrival from the hospital. The handwritten form revealed that the investigation findings were concluded at 2:30 p.m. on December 27, 2025, and found that the patient did receive care throughout the night when he arrived, again at midnight, and lastly when the nurse checked on his feeding pump. The facility's actions were to remind staff to do care in pairs, and to shower the resident to make sure he was cleaned. The handwritten form also revealed that the patient was informed that the Registered Nurse (RN/Staff #46), would not be providing care for him, as requested. A telephonic interview was conducted on March 18, 2026, at 9:33 a.m. with Resident #70's wife, who stated that her husband was abused and neglected at the facility on the night of December 26, 2025, into December 27, 2025, and that she reported the allegation to the facility administration that day. Resident #70's wife stated that the night shift Registered Nurse (RN/Staff#46) and a Certified Nursing Assistant (CNA/Staff#13) responded to Resident #70's call light for a brief change after he spilled his bedside urinal on his leg, and that they turned him back and forth aggressively during the brief change. The resident's wife stated that the resident asked staff to stop, and that Staff #46 made a comment to the staff member who was assisting that they needed to get out of the room or else he would get them fired. The resident's wife further stated that staff ignored him for the rest of the night and left his bed remote out of his reach. Resident #70's wife stated that there were two police reports filed regarding abuse and neglect during her husband's stay at the facility, one on December 22, 2025, and another on December 27, 2025. Resident #70's wife stated that the incident from December 27, 2025, was never reported by the facility to any state agency except the police, and that the ED, Staff #74, told her he was not going to report the incident because he did not deem it necessary. A telephonic interview was attempted on March 18, 2026, at 10:16 a.m. with a CNA, Staff #13, but was unsuccessful.A telephonic interview was conducted on March 18, 2026, at 10:19 a.m. with an RN, (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #46, who stated that the timeframe for reporting abuse and neglect was right away to the administrator, and that she has never had anyone report or make an allegation of abuse, neglect, or rough care to her, or against her. The RN initially stated that she did not recall Resident #70, however, she later stated she could recall him. The RN stated that Resident #70 was very aggressive with staff, he refused care a lot, including care for his tube feeding, and she did not know if he had ever reported abuse or neglect. The RN further stated that Resident #70 did not like one of the CNA's, but she could not recall who, and she stated that the resident never asked her to stop during care. The RN stated that she heard that there was an incident with three staff members who were fired, and that the resident told her he did not like two of the staff members, one CNA, Staff #13, and a Licensed Practical Nurse (LPN/Staff#86), and that he did not want to see them again, which was reported to the previous Director of Nursing (Previous DON/Staff#82). The RN also stated that she did not ignore Resident #70, and that she did not make the statement that they needed to get out of the room or else he would get them fired. A telephonic interview was attempted on March 18, 2026, at 10:44 a.m. with the previous Director of Nursing (Previous DON/Staff#82), but was unsuccessful.A telephonic interview was conducted on March 18, 2026, at 11:31 a.m. with the ED, Staff #74, who stated that the timeframe for reporting allegations of abuse and neglect was right away for staff, but he needed to report to the Arizona Department of Health Services (AZDHS), Adult Protective Services (APS), the police, the ombudsman, the medical director, and the DON within one hour. The ED stated that, in the last four months, the facility has only had one self-report regarding Resident #70, that it had already been investigated, and that the date of the incident was December 22, 2025. The ED stated that on December 26, 2025, he completed the 5-day report for the previous incident, and that the incident on the 27th was not abuse. The ED stated that the resident was at the hospital on December 26, 2025, and that the wife of Resident #70 reported to him that the resident was neglected on December 27, 2025. The ED stated that he came into the facility over that weekend to talk to the resident's wife after the admissions staff called him to say that the wife of Resident #70 made an allegation of neglect for her husband. The ED further stated that he sat in his office with Resident #70's wife, and then he went to talk with the resident, who contradicted the wife's allegation of neglect. The ED also stated that if he had two statements, one person saying something happened, and another person saying the opposite happened, he would not report it. The ED stated that he reported the incident from December 22, 2025, because the nurse said the incident happened, but that he did not report the incident from December 27, 2025, to any state agency, and he initially stated that he did not call the police for the incident on December 27, 2025, however, he then stated that he did call the police because Resident #70's wife wanted to file a police report. The ED also stated that he told Resident #70's wife that he was not going to report it because the resident told him he was not being neglected, and that he took written statements from staff regarding the incident from the 27th. A telephonic interview was attempted on March 18, 2026, at 12:08 p.m. with Resident #70, but was unsuccessful.A telephonic interview was conducted on March 18, 2026, at 2:03 p.m. with an LPN, Staff #86, who stated that the timeframe for reporting allegations of abuse and neglect was as soon as possible to the DON, and that she could recall Resident #70. The LPN stated that the resident was not under her care, but she worked with him a few times because he made allegations against the RN, Staff #46, and that the previous DON, Staff #82, instructed the LPN to switch with the RN to prevent further escalation of the situation.A telephonic interview was conducted on March 18, 2026, at 2:12 p.m. with a CNA, Staff #51. The CNA stated that she recalled Resident #70, and stated that the resident got three staff members fired for a prior incident. The CNA further stated that the resident was receiving two-person care at all times, she refused to go into his room because of his history of making allegations, but they were short-staffed on December 26, 2025, so she was asked by two CNAs, Staff #13 and Staff #10, on two different occasions that night to assist with two-person care. The CNA stated that the resident spilled his bedside urinal, they completed a full bed change, and she left the room until the last rounds of her shift at 5 a.m. on December 27, 2025. The CNA stated that (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the previous DON, Staff #82, called her later that same day because she was supposed to work again that afternoon, and told her not to come in because Resident #70 reported that the night shift had neglected care for him all night, and that they needed her to write a statement. The CNA also stated that she was not suspended, but that the facility needed her to wait to clock in until they investigated the allegation, and she worked again that night, around 6 p.m. The CNA stated that she did not speak with police about the incident, and that she had only spoken to the previous DON about it. The CNA also stated that the resident made allegations against the RN, Staff #46. A telephonic interview was conducted on March 18, 2026, at 2:31 p.m. with a CNA, Staff #10. The CNA stated that she recalled Resident #70, and that he never made an allegation of abuse or neglect. The CNA further stated that she was told to only give care to the resident in pairs with another staff member because he was having issues with staff and saying that no care was being given. The CNA stated that there was another incident with the resident before involving staff members being fired, and that after that incident, he reported that he was not getting care. The CNA stated that she would not check on the resident unless he pressed his call light because that was his preference, and that she was told that the wife of Resident #70 reported that they were neglecting him.Review of a policy titled, Abuse - Identification of Types, with a review date of May 6, 2025, revealed that abuse was defined as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy further revealed that abuse also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The policy also revealed that neglect was defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Review of a policy titled, Abuse - Reporting and Response - No Crime Suspected, with a review date of May 7, 2025, revealed that, in response to allegations of abuse and neglect, all alleged violations needed to be reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or no later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury to the administrator and to other officials, including the State Survey Agency and Adult Protective Services. The policy further revealed that an individual who reports an alleged violation would not have to explicitly characterize the situation as abuse or neglect to trigger a facility investigation; if staff could reasonably conclude that the potential exists, it would be considered reportable and required action. The policy also revealed that all alleged violations, whether oral or in writing, must be reported to the administrator of the facility and to other officials in accordance with State law through established procedures. The policy further revealed that the facility must provide sufficient information to describe the alleged violation and indicate how residents are being protected in its report, and within 5 working days of the incident, the facility must provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.