

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/20/2026
NAME OF PROVIDER OR SUPPLIER MI Casa Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record review, weather data review, and review of facility policy and procedure, the facility failed to provide adequate supervision for one resident (#109) who was assessed to have poor safety awareness and required assistance with mobility, while in the courtyard during extreme summer temperatures. Sampled residents for accidents were 3. As a result, Resident #109 remained outdoors for an undetermined period of time in temperatures reaching 103 F and sustained second-degree burns to both thighs requiring emergency medical treatment at the hospital. Findings include: Resident #109 was readmitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus with diabetic neuropathy, muscle weakness, cognitive communication deficit, and tobacco use. A readmission Elopement Risk assessment dated [DATE], revealed Resident #109 did not ambulate independently with or without the use of a wheelchair or other assistive device. The documentation included the resident was not an elopement risk at this time. A Skilled Progress Note dated July 11, 2026, at 9:49 p.m., revealed Resident #109 was alert and oriented but had poor safety awareness; and that, Resident #109 liked to go out to the courtyard periodically and had been instructed not to go outside during the afternoon due to hot weather. An Event Progress Note dated July 12, 2026, at 3:38 p.m., revealed Registered Nurse (RN/Staff #25) and the physician (staff #99) found resident #109 unresponsive in the courtyard and was assisted by two Certified Nursing Assistants (CNAs/Staff #80 and #73) in bringing inside. Per the documentation, 911 was called at 2:18 p.m.; and, the resident was subsequently transported to the hospital by emergency medical services. The note further documented that another resident (#103) who observed from her room window reported Resident #109 entered the courtyard independently and remained outside for approximately 30 to 45 minutes. Review of weather data obtained from the National Oceanic and Atmospheric Administration (NOAA) for July 12, 2026, revealed temperatures of 103 F at both 12:53 p.m. and 1:53 p.m. Conditions were reported as clear with relative humidity levels of 26 percent at 12:53 p.m. and 24 percent at 1:53 p.m. The Emergency Department Report dated July 12, 2026, revealed Resident #109 was evaluated after being found outside at his care facility. The report indicated he may have been outdoors for approximately 20 minutes to one hour. Upon arrival at the emergency department, Resident #109 had a temperature of 38.4 C (101.1 F) and was treated for second-degree burns to his bilateral thighs. An Admission/readmission Note dated July 12, 2026, revealed Resident #109 returned from the hospital at approximately 9:00 p.m. The note documented second-degree burns to both thighs with intact blisters. The physician order dated July 13, 2026 revealed an order to cleanse wound with normal saline or wound cleanser, apply Xeroform (non-adherent medicated gauze), cover with dry dressing to BLE (bilateral lower extremities) every day shift for burns. Review of a Care Plan entry dated July 13, 2026, revealed a new focus identifying (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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