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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Palms Post Acute	6461 East Baywood Avenue 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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NAME OF PROVIDER OR SUPPLIER Mission Palms Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6461 East Baywood Avenue 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 0686 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 clinical record review, interviews, and facility policy, the facility failed to ensure appropriate monitoring of negative pressure wound therapy (NPWT) (wound vac) for 1 of 4 residents (Resident #4). The deficient practice could result in the potential for the wound vac therapy to be ineffective and cause wounds to get worse. Findings include:Resident # 4 was admitted [DATE], with diagnosis of Parkinson's, type 2 diabetes mellitus, and peripheral vascular disease. Review of Resident #4's care plan dated March 20, 2025 revealed that resident has potential for pressure ulcer development with actual skin impairment, including left lateral foot diabetic foot ulcer. Interventions included administering treatments as ordered and monitoring for effectiveness, as well as monitoring the dressing to ensure it is intact and adhering. The Minimum Data Set (MDS) dated [DATE] revealed that Resident # 4's Brief Interview for Mental Status (BIMS) score was 14 which indicated Resident # 4 is cognitively intact. The MDS also revealed that Resident # 4 was at risk for developing pressure ulcers. Review of surgical debridement note dated July 16, 2025, revealed wounds located on the left lateral foot measuring 2.0 cm x 1.0 cm x 0.6 cm and left lateral ankle measuring 2.7 cm x 2.0 cm. x 0.5 cm. Review of a skin evaluation dated August 11, 2025, revealed a wound vac treatment to the patient's left foot. An order dated August 11, 2025, revealed wound vac monitoring every shift for functioning and placement. The order clarified if the wound vac malfunctions or must be off for more than two hours staff would need to follow as needed (PRN) orders in treatment administration record (TAR) for additional instructions. Review of the additional instructions included to cleanse wound to left foot and left lateral ankle with wound cleanser and to apply wet to moist dressing and secure with tape. This dressing was to be changed every 12 hours until the wound vac is replaced, and to notify the wound nurse that the wound vac is off. Review of the wound team administration record for August 2025 revealed that monitoring wound vac placement was not marked as completed on August 17, 2025, for the overnight shift. Review of MAR administration note dated August 18, 2025 at 12:44 p.m. revealed that Resident # 4 reported discomfort to left foot. Wound vac was removed and skin to peri wound was macerated from drainage due to seal broken. Wound was cleansed with wound cleanser, patted dry and skin prep was applied to peri wound as well as triad paste, Medi honey, and silver alginate. Wound was wrapped and Hospice was notified. It also revealed that wound vac was held for remainder of the night and the wound would be reassessed tomorrow. Review of MAR administration note dated August 19, 2025 at 7:31 a.m. revealed that wound vac was still on hold due to maceration of peri wound and discomfort reported by resident. Review of wound team administration record for August 2025 revealed that cleansing of the wound and changing of the dressing every 12 hours while wound vac was off was not completed on August 18, 19, and 20th, 2025. Review of surgical debridement note dated August 20, 2025, revealed wounds located on left lateral foot measuring 1.5 cm x 1. 1 cm x 0.5 cm and left lateral ankle measuring 2.5 cm x 2.3 cm. x 0.6 cm. An interview with Resident # 4 on August 25, 2025 at 11:58 a.m. revealed that he had started the wound vac on his left foot in mid-August and had it on for about five days when he started to feel pain in his left foot. He informed staff and they took it off and wrapped it. Resident # 4 revealed that he felt the wound vac had made the wounds worse. An interview with Licensed Practical Nurse (LPN/Staff # 128) on August 25, 2025 at 3:00 p.m. revealed that Resident # 4 had a wound vac on but it was removed last week due to a leak in the seal. Staff #128 revealed that they help monitor the wound vac each shift to ensure there are no leaks in the seal. After the vac is monitored then they mark the MAR and follow any other orders given by the physician. If there is a leak in the seal, they need to stop wound vac and notify physician immediately and follow any instructions they give.An interview with Director of Nursing (DON/Staff # 193) on August 25, 2025 at 4:02 p.m. revealed that it is his expectation that the floor nurses monitor the wound vac every 12 hours for any seals and notify the physician if there are any problems with the wound vac such as a break in the seal. DON Staff # 193 revealed that the overnight nurse did not sign off on monitoring the wound vac the night of August 17, 2025 and that it is his expectation that the wound vac be monitored every shift. A Policy and Procedure titled Wound Management dated as reviewed on September 2024, revealed that a resident having a pressure ulcer receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable sores from developing. Once a wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's order. The policy also revealed that all wound or skin treatments should be documented in the resident's clinical record at the time they are administered.