

Acceptable PAC
12/30/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER OASIS NURSING & REHAB OF GREEN VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELMAR GARDENS DRIVE , HENDERSON, Nevada, 89074	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare Recertification, Complaint and Facility Reported Incident (FRI) Survey conducted in your facility from 09/23/2025 through 09/26/2025, in accordance with 42 Code of Federal Regulations (CFR), Chapter IV, Part 483, Requirements for Long Term Care Facilities. The census at the time of the survey was 189. The sample size was 51. There were four complaints and two FRIs investigated. 1) Complaint 2287283, deficient practice was not identified. 2) Complaint 2287288, deficient practice was identified (See F677). 3) Complaint 2287292, deficient practice was not identified. 4) Complaint 2610547, deficient practice was not identified. 5) FRI 2287290, deficient practice was not identified. 6) FRI 2287291, deficient practice was not identified. The investigation included: Observation of staff providing care and supervision to residents, staff to resident interactions, resident to resident interactions, tray line, and a tour of the facility. Interviews were conducted with certified nursing assistants, maintenance director, dietary manager, laundry manager, housekeeping, treatment nurse, social work director, social work assistant, licensed nurses, registered dietitian consultant, nurse practitioner, director of nursing, and administrator. Clinical record review of residents which included	F0000	Public Notice Disclaimer: <u>The plan of correction is signed and submitted as required under State and Federal Law.</u> The signing and submissions of this plan does not constitute an admission on the part of Oasis Nursing and Rehabilitation of Green Valley ("facility") as to the accuracy of the surveyor's findings or the conclusions drawn there from. <u>The plan of correction does not constitute an admission on part of the facility or employees that the findings cited as accurate, that the findings constitute a deficiency or the scope and severity regarding any of the deficiencies cited is correctly applied.</u> Any changes to facility policies and procedures shall be considered to be subsequent remedial measures as that concept is applied in Rule 407 of the Federal Rules of Evidence and NRS 48.095 and shall be inadmissible in any proceeding on that basis. The facility submits this plan of correction with the intention that it shall be inadmissible by any third party in any regulatory, civil or criminal action against the facility or any employee, agent officer, director or shareholder of the facility.	

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 reverse for further 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 <i>Chandra N. B. [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/22/25</i>
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F0000	Continued from page 1 residents of concern.		F0000				
F0552 SS = D	Document review included facility policy and procedures, grievance log, resident council meeting minutes, maintenance work logs, and FRI investigation files. The findings and conclusions of any investigation by the Division of Purchasing and Compliance shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified. Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and document review, the facility failed to ensure each resident or resident's guardian provided signed evidence of informed consent prior to the administration of a psychoactive medication, for 2 of 51 sampled residents (Residents 169 and 191). The deficient practice had the potential to put residents at risk of using psychoactive medication without understanding the risks and benefits of the medication.		F0552	F0552 Right to be informed /Make Treatment Decisions The facility will continue to ensure that residents are informed of, and are able to participate in, his or her treatment. Resident (R169) psychotropic medication consent form was immediately obtained on 09/23/2025 from the responsible party and placed in the resident's medical record. Resident (R169) continues to reside in the facility and is receiving care according to physician's orders and plan of care. Resident (R191) psychotropic medication consent form was obtained on 09/23/2025 and placed in the resident's medical record. Resident (R191) continues to reside in the facility and is receiving care according to physician's orders and plan of care. A comprehensive audit of all residents receiving psychotropic medications was completed to verify that signed consent forms are present in each medical record. Any missing or incomplete			

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F0552 SS = D	Continued from page 2 Findings include: 1) Resident 169 (R169) was admitted on 04/08/2022 with diagnoses including bipolar disorder. The medical record indicated a guardian had been appointed to make medical decisions for R169. A Physician Order dated 09/20/2024 indicated to give Quetiapine (an antipsychotic medication) 25 milligrams (mg) at bedtime for mood related to bipolar disorder. A review of the September 2025 Medication Administration Record (MAR) revealed the resident had taken Quetiapine every evening of the month. The MAR indicated R169 was monitored for potential side effects of the Quetiapine which included constipation, blurred vision, and confusion. The record lacked documented evidence the guardian had given informed consent for the use of the Quetiapine. On 09/26/2025 at 1:25 PM, the Director of Nursing (DON) indicated nurses were supposed to contact the resident or resident's representative/family, explain the risks and benefits of using the medication, and then if consent was given, document the consent in the record. The DON verified R169s record lacked documented evidence informed consent had been obtained for R169 to use Quetiapine starting on 09/20/2024. The DON verbalized consent should have been obtained prior to starting the medication. 2) Resident 191 (R191) was admitted on 01/04/2023, and readmitted on 04/06/2025, with diagnoses including dementia, depression disorder, polyneuropathy, chronic obstructive pulmonary disease and bipolar disorder. A Physician Order dated 09/05/2025 documented Sertraline Hydrochloride (HCl) oral tablet 50 milligrams (mg), give one tablet by mouth one time a day for verbalization of sadness related to major depressive disorder. R191's medical record lacked documented evidence an informed consent was obtained prior to the first administration of Sertraline (HCl) on 09/05/2025. On 09/26/2025 at 12:33 PM, a Licensed Practical Nurse (LPN), stated if the resident was alert, the resident was asked to sign the medication consent form. If the resident was not alert, the resident's representative or family member was contacted to obtain consent.	F0552	consents were immediately addressed with the resident and responsible parties. The DON/designee will audit all new medication orders daily and new admission orders within 24 hours to ensure that any newly prescribed psychotropic medication has a corresponding signed consent form prior to administration. The DON/designee will audit six resident charts each week for 12 weeks of residents receiving psychotropic medications, ensuring that consent forms are fully completed and included in the medical record. Any missing or incomplete consents identified during daily order checks or weekly audits will be corrected immediately. Audit results will be reported and reviewed during monthly QAPI meetings to maintain compliance. Nursing staff were reeducated on 12/1/2025 on obtaining and documenting consent for psychotropic medications prior to administration, and this education will be ongoing. Training emphasized proper consent form completion, and documentation. New nursing staff will receive training on psychotropic medication consent requirements ongoing and during orientation. Ongoing education will be provided as needed based on audit results. Any deficiencies will be addressed immediately with corrective action and staff re-education. Completion date: December 5, 2025	

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F0552 SS = D	Continued from page 3 On 09/26/ 2025 at 1:18 PM, the Director of Nursing (DON), indicated before a resident could be placed on a psychotropic medication, a consent must be obtained and a consent form signed. If the resident was not alert, the family or legal representative needed to sign the consent form. If the resident was alert, the resident was required to sign the consent. The DON indicated psychotropic medications should not be administered without a signed consent form. The facility policy titled "Psychotropic Medication Use", effective 07/2022, documented residents (and/or representatives) have the right to decline treatment with psychotropic medications. The staff and physician will review with residents/representatives the risks related to not taking the medication as well as appropriate alternatives.			F0552			
F0637 SS = D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and document review, the facility failed to ensure a significant change in status assessment was completed for a hospice resident for 1 of 3 closed record sampled residents (Resident 200). The deficient practice had the potential for a hospice plan of care to not be generated. Findings include: Resident 200 (R200) was admitted on 01/18/2025, with diagnoses including Alzheimer's dementia and protein-calorie malnutrition. An Alert Note dated 07/24/2025 revealed R200 was admitted to hospice care.			F0637	F0637 Comprehensive Assessment Significant Change The facility will continue to complete comprehensive MDS assessments after a significant change in the resident's physical or mental condition. Resident (R200) no longer resides in the facility. A house-wide audit was conducted of all residents who elected hospice services to identify any other instances where a significant change in status MDS assessment may have been missed. No other residents were identified as being affected. A change of condition form is available at all facility units for staff to notify the DON when a resident has a change in physical or mental condition. The MDS Coordinators were re-educated on the criteria for a Significant Change in Status Assessment including changes in care related to hospice election on 10/06/2025,		

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F0637 SS = D	Continued from page 4 The medical record lacked documented evidence that a significant change in status assessment was completed when R200 was admitted to the hospice program on 07/24/2025. On 09/26/2025 at 8:20 AM, the Minimum Data Set (MDS) Coordinator reviewed R200's medical record and confirmed R200 was admitted to the facility on 01/18/2025 and was enrolled into the hospice program on 07/24/2025. The MDS Coordinator acknowledged that a significant change in status assessment was not completed for R200 in accordance with resident assessment instrument (RAI) requirements. On 09/26/2025 at 8:30 AM, the MDS Coordinator explained the facility had 14 days to complete a significant change in status assessment from a resident's admission into hospice in accordance with the RAI manual and the assessment would then generate a hospice care plan. The MDS Coordinator explained that MDS staff were informed of changes in condition by 1) business office due to payor source change, 2) daily stand-up meetings and/or 3) direct communication by nursing staff. The MDS Coordinator indicated being newly hired in June 2025 and was not attending stand-up meetings in July 2025. On 09/26/2025 at 9:56 AM, the Director of Nursing (DON) confirmed there was no significant change in status assessment completed for R200 which was due 14 days after R200's enrollment into hospice for the purpose of generating a hospice care plan. On 09/26/2025 at 11:23 AM, the Medical Records Director confirmed R200 did not have a significant change in status assessment. The RAI Version 3.0 Manual dated October 2023, revealed a significant change in status assessment was required when a terminally ill patient enrolled into the hospice program. The assessment reference date must be within 14 days from the date of the hospice election. The significant change in status assessment must be performed regardless of whether an assessment was recently conducted on the resident.	F0637	and this education will be ongoing. New nursing staff will receive training on Significant Change in Status requirements during orientation. The MDS team added a weekly review of new hospice cases during IDT meetings to ensure assessment compliance. The DON or designee will audit all new hospice admissions weekly for 12 weeks, and monthly thereafter to ensure "significant change in status" MDS assessments are completed as required. Audit results will be reported to the QAPI Committee monthly. Completion date: December 5, 2025		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the	F0657	F0657 Care Plan Timing and Revision The facility will continue to develop and		

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F0657 SS = D	Continued from page 5 comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and document review, the facility failed to develop a hospice care plan for 1 of 3 closed record sampled residents (Resident 200). The deficient practice had the potential to place the resident at risk for receiving inadequate hospice care. Findings include: Resident 200 (R200) was admitted on 01/18/2025, with diagnoses including Alzheimer's dementia and protein-calorie malnutrition. An Alert Note dated 07/24/2025 revealed R200 was admitted to hospice care. The medical record lacked documented evidence that a hospice care plan was developed after R200 was admitted to hospice. On 09/26/2025 at 8:30 AM, the Minimum Data Set (MDS) Coordinator confirmed a hospice care plan was not developed when R200 enrolled into hospice on 07/24/2025 because the significant change in status assessment was	F0657	implement a comprehensive person-centered care plan, including measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. Resident (R200) no longer resides in the facility. A house-wide audit was conducted at the time of survey of all residents currently receiving hospice services to ensure each has a clearly defined, individualized hospice care plan, and evidence of coordination with hospice staff. No other hospice residents were identified as being affected. The Care Plan Nurse and MDS coordinators were in-serviced on care planning requirements for hospice residents, including incorporating the hospice agency's plan of care. on 10/06/2025, and this education will be ongoing. New nursing staff will receive training on care plan requirements during orientation. The DON or designee will audit care plans of all new hospice admissions weekly for 12 weeks, and monthly thereafter to ensure hospice-specific care plans are in place. Audit findings will be reviewed during QAPI meetings monthly. Completion date: December 5, 2025	

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F0657 SS = D	Continued from page 6 not completed in accordance with resident assessment instrument (RAI) requirements. On 09/26/2025 at 9:56 AM, the Director of Nursing (DON) explained there was no significant change in status assessment completed within 14 days from R200's admission to hospice and may have been the reason a hospice care plan was not developed. The DON revealed hospice care plans typically included a goal focused on the resident's comfort and common interventions included pain management, following advanced directives and coordination between the facility and the hospice provider. The facility policy titled "Comprehensive Person-Centered Care Plan", revised March 2022, documented a person-centered comprehensive care plan was developed within seven days of a significant change in status assessment. The interdisciplinary team would review and update the care plans after a significant change in the residents' condition.	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and document review, the facility failed to ensure showers were provided as scheduled for a resident who required assistance with bathing for 1 of 51 sampled residents (Resident 202). The deficient practice had the potential to result in poor hygiene, increased risk for skin breakdown and negatively affect resident's dignity and psychosocial well-being. Findings include: Resident 202 (R202) was admitted to the facility on 03/27/2025 and discharged on 06/01/2025 with diagnoses including Wernicke's encephalopathy, alcohol-induced chronic pancreatitis, and auditory hallucinations. The resident census documented R202 resided in room 203B from 03/27/2025 to 05/08/2025, and room 207B from 05/08/2025 to 06/01/2025. The facility document titled Preferred Shower Schedule	F0677	F0677 ADL Care Provided for Dependent Residents The facility will continue to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene. Resident (R202) no longer resides in the facility. The facility has updated the shower documentation form to include more detailed information, such as whether the resident refused the shower, in addition to the date and time the shower was provided. The DON implemented new shower binders for each hall, organized by the shower schedule specific to that hall. Nursing staff will be required to file all shower forms in the binder	

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F0677 SS = D	Continued from page 7 for the 200-hall documented 203B was to receive showers on day shift Wednesday and Saturday. Room 207B was to receive showers on evening shift Tuesdays and Fridays. A Care Plan dated 04/07/2025 documented R202's had an Activities of Daily Living (ADL) self-care performance deficit related to encephalopathy, malnutrition, pancreatitis and pain with interventions including provide sponge bath when a full bath or shower could not be tolerated. The Admission Minimum Data Set (MDS) dated 04/01/2025 documented R202 required maximal assistance with shower/bathe self: the ability to bathe self, including washing, rinsing, and drying self (which excluded washing of back and hair). The facility ADL documentation for May 2025 documented a shower for R202 occurred on 05/13/2025 evening shift. On 09/25/2025 at 1:20 PM, Certified Nurse Assistant 4 (CNA4) explained when resident care was provided it was documented in the resident's chart. CNA4 explained that the documentation included all Activities of Daily Living (ADL) assistance provided including things such as showers, brief changes, and transfers. On 09/26/2025 at 9:29 AM, Certified Nurse Assistant 5 (CNA5), explained the residents had shower schedules and the bathing occurred twice a week. CNA5 explained completing skin shower sheets when showers were done, and the sheets were signed by a nurse. CNA5 explained the showers were documented in the resident's electronic record. On 09/26/2025 at 9:32 AM, a Registered Nurse (RN) reviewed R202's ADL bathing document for May 2025 and stated the lack of documentation looked like showers were not completed as assigned. On 09/26/2025 at 10:00 AM, the Director of Nursing (DON) confirmed showers for residents were scheduled twice a week along with staff completion of skin shower sheets. The DON explained the CNAs were to chart completion of bathing in the resident's electronic medical record. On 09/26/2025 at 11:54 AM, the DON reviewed R202's ADL documentation for May 2025 and confirmed one episode of bathing had been documented on 05/13/2025. On 09/26/2025 at 1:43 PM, the Medical Records Director was unable to locate additional May 2025 skin shower sheets for R202.			F0677	immediately after the shower is provided or refused. The DON/Designee will audit CNA charting daily to ensure that showers are being documented in the electronic medical record. The DON/or designee will conduct weekly audits of the shower binders to ensure that all required documentation is complete and maintained on an ongoing basis. Any missing shower forms or incomplete documentation will be addressed immediately with the staff member responsible. Nursing staff received in-service training on the updated shower form, proper documentation requirements, and the new shower binder system on <u>12/1/2025</u> and this education will be ongoing. Education included instruction on documenting resident refusals and timely filing of shower sheets in the designated binder. New nursing staff will receive training in these procedures during orientation. Ongoing education and competency checks will be conducted as needed based on audit findings. Results of the audits will be reviewed in monthly QAPI meetings to identify trends, compliance issues, and opportunities for further education or corrective action. Completion date: December 5, 2025		

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F0677 SS = D	Continued from page 8 The facility policy titled "Activities of Daily Living , Supporting", revised March 2018, documented appropriate care and services would be provided for residents who were unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). Complaint 2287288	F0677		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure 1) a risk assessment for pressure ulcer development was completed and 2) a new skin impairment was identified and addressed for 1 of 51 sampled residents (Resident 12). The deficient practice had the potential to place the resident at risk for new or worsening pressure ulcers. Findings include: Resident 12 (R12) was admitted on 02/17/2023 and readmitted on 07/08/2025, with diagnoses including end stage renal disease (ESRD), and acute osteomyelitis of ankle and foot. On 09/23/2025 at 9:55 AM, R12 was alert while seated in wheelchair. R12 recounted being hospitalized in July	F0686	F0686 Treatment/Services to Prevent/Heal Pressure Ulcer The facility will continue to ensure that residents receive care consistent with professional standards of practice, to prevent pressure ulcers and do not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable. Resident (R12) continues to reside in the facility and is receiving care according to physician's orders and plan of care. The DON/Nurse management team assessed all residents for wounds or skin concerns, and findings were documented and addressed accordingly. The DON/designee will audit all new admissions within 24 hours to ensure completion of skin risk assessments. The shower sheet form has been updated to include clearer prompts for staff to assess and document any skin concerns, including wounds, redness, or other abnormalities. The DON implemented shower binders for each hall, organized according to the specific	

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F0686 SS = D	Continued from page 9 2025 and a right foot wound was identified by emergency department (ED) staff which according to the resident was a new wound. R12 indicated being treated for osteomyelitis with intravenous (IV) antibiotics which was resumed upon returning to the facility. 1) The facility policy titled "Pressure Injury Risk Assessment", revised March 2020, documented to use a facility-approved risk assessment tool to identify a resident's risk for developing new or worsening pressure injuries. The assessment should be conducted as soon as possible after admission, weekly for the first four weeks, when there was a significant change in condition or as often as required based on the resident's condition. If a new skin alteration was identified, there must be documentation of physician notification. On 09/26/2025 at 1:37 PM, the Clinical Resource Nurse indicated the facility utilized the Braden skin assessment tool for determining a resident's risk for developing pressure injuries. The Braden assessment must be completed on admission, readmission and on a quarterly basis. A Braden assessment dated 02/18/2023, revealed R12 was at risk for developing pressure ulcers due to being chairfast and limited mobility. The medical record lacked documented evidence staff completed a Braden assessment for R12 since 02/18/2023 (initial admission). On 09/26/2025 in the afternoon, the Clinical Resource Nurse and Medical Records Director confirmed there had been one Braden assessment completed for R12 since admission to the facility on 02/18/2023. 2) A Skin Assessment conducted on 07/02/2025, revealed R12's skin was intact with no skin impairments. A Nutrition Note dated 07/02/2025, revealed R12 had intact skin. A Nurse's Note dated 07/05/2025, revealed R12 was transferred to the hospital due to yellowish-green emesis. A Hospital Consultation Report dated 07/06/2025, documented R12's wounds which were present on admission included 1) a full thickness ulcer on right lateral foot with red granulation tissue and undermining, 2) a scabbed wound on the base on right fifth toe.	F0686	shower schedule for that hall. Staff are required to file completed shower sheets in the binder immediately after the shower is provided or refused. The charge nurses will perform weekly skin risk assessments on each resident to ensure any changes in skin integrity are addressed. The DON/designee will audit 6 skin risk assessments weekly x 12 weeks to ensure the skin assessments are complete and skin concerns are addressed. The nurse management team will conduct weekly audits of all the shower binders weekly x 12 weeks to ensure documentation is present, complete, and timely. Any missing or incomplete documentation is addressed immediately with the staff member responsible. The nursing staff received in-service training on the revised shower documentation form, proper wound and skin integrity documentation, procedures for documenting refusals and filing protocols using the new binder system on <u>12/1/2025</u> and this education will be ongoing. All newly hired nursing staff receive training on these procedures during their orientation. Ongoing education and competency checks will be conducted based on audit findings.	

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F0686 SS = D	Continued from page 10 A Hospital Discharge Summary dated 07/08/2025, revealed a wound consult for R12's right foot occurred due to wounds present on admission. Discharge medications included Meropenem 500 milligrams (mg) intravenously (IV) once daily for 10 days for osteomyelitis. A Readmission Note dated 07/08/2025, revealed R12 returned to facility after being treated for nausea and vomiting and foot wound osteomyelitis. A Nurse's Note dated 07/08/2025, documented R12 arrived in a stretcher, dressing on right arm for IV and a right foot wound covered with dressing. A Skin/Wound Note dated 07/10/2025, revealed right lateral foot wound measured 15 millimeters (mm) length x 14 mm width x 3 mm depth with scant serosanguinous discharge. Wound bed with 50 percent (%) eschar and 50% granulation. On 09/26/2025 at 8:10 AM, a Treatment Nurse indicated being familiar with R12 since the nurse was treating R12's sacral wound which had resolved in June 2025. No new skin impairments were reported to the treatment team by the floor nurses regarding a right foot wound, but the treatment nurse recalled being informed R12 returned from the hospital with a right foot ulcer which was being treated with IV antibiotics. On 09/25/2025 at 3:32 PM, the Director of Nursing (DON) reviewed R12's medical record and indicated R12's right foot wound appeared to be facility-acquired not identified during the last weekly skin check on 07/02/2025. The DON indicated not performing skin checks in accordance with the facility's protocols, placed residents at risk for infection, development of new wounds, worsening of existing wounds and delay in appropriate interventions. The facility policy titles "Prevention of Pressure Injuries", revised April 2020, documented skin checks were done within eight hours from admission, weekly and when there was a change in condition. Inspect the skin daily when performing care or activity. Document and report any changes in skin.			F0686	A change of condition form is available at all facility units for staff to notify the DON when a resident has a change in skin/physical or mental condition. Audit results will also be reviewed in monthly QAPI meetings to Monitor for trends, identify recurring compliance issues, guide additional training or corrective actions as needed. Completion date: December 5, 2025		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -			F0689	F0689 Free of Accident Hazards/Supervision The facility will continue to ensure the resident environment remains as		

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F0689 SS = D	Continued from page 11 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure adequate supervision and a safe environment to prevent a resident with cognitive impairment from accessing and ingesting non-food items for 1 of 51 sampled residents (Resident 17). The deficient practice had the potential to result in choking, gastrointestinal upset or other adverse health outcomes. Findings include: 1) Resident 17 (R17) was admitted on 11/01/2024 with diagnoses including unspecified dementia, hyperglycemia, and bipolar disorder. A Brief Interview for Mental Status (BIMS) evaluation dated 09/15/2025 documented a score of zero indicating R17 had severe cognitive impairment. A Progress Note dated 09/20/2025 documented R17 was taking sugar packets from the service area and was redirected. A Progress Note dated 09/22/2025 documented R17 was rummaging and taking sugar packets. When staff attempted to take sugar packets away, the resident started yelling R17 was given space, R17 eventually sat down, and staff were able to take some of the sugar packets. A Care Plan dated 10/14/2024 documented R17 was at risk for harm related to wandering throughout the unit and hoarding. On 09/25/2025 at 7:50 AM, R17 obtained multiple yellow packets of artificial sweetener from a drawer in the service area. A Licensed Practical Nurse (LPN) attempted to remove the packets from R17's hand and was unsuccessful. The LPN explained R17 liked to eat sugar and would sometimes eat the packet. On 09/25/2025 at 8:04 AM, R17 was pacing back and forth in the service area and placed an entire yellow packet of artificial sweetener into mouth and began to chew.	F0689	free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. An activity staff member has been added to work on the memory care unit 7 days a week to provide additional supervision and assistance. Resident (R17) continues to reside in the facility and is receiving care according to physicians' orders and plan of care. The broken drawer was repaired immediately. The locks on the two wooden cabinets were replaced. All Staff were re-educated on the requirement to keep refrigerators and cabinets locked at all times on the memory care unit on <u>12/5/2025</u> and this education will be ongoing . New staff will receive training in these procedures during orientation. Competency checks will be conducted as needed based on audit findings. A Refrigerator/Cabinet Safety Check Log was implemented, requiring nursing staff to confirm the locked status of refrigerators and cabinets on the memory care unit hourly. Memory care staff received in-service training on the procedure for reporting equipment issues to maintenance and, if needed, following up with the administrator. The Director of Maintenance/designee will conduct weekly inspections of locking				

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F0689 SS = D	Continued from page 12 The LPN approached R17 and attempted to get R17 to spit the packet out and R17 continued to chew, pushed past the nurse and began walking down the hall. The facility policy titled "Behavioral Assessment, Intervention and Monitoring", revised March 2019, documented safety strategies would be implemented immediately if necessary to protect the resident and others from harm. 2) On 09/23/2025 at 8:10 AM, an inspection of the specialty care unit revealed two wooden cabinets with broken locks. The Director of Maintenance confirmed the cabinet locks were broken. Certified Nursing Assistant 1 (CNA1) confirmed the first cabinet contained approximately 200 sugar packets, 100 packets of artificial sweeteners, a box of breakfast syrup, and a variety of condiments such as catsup, mustard, cream of tartar and salt. The second cabinet contained three open bottles of liquid hand soap. On 09/23/2025 at 8:15 AM, CNA1 explained the specialty care unit housed 17 residents with a diagnosis of dementia and all cabinets and refrigerators must be kept secure and contents inaccessible for safety reasons. On 09/23/2025 at 8:20 AM, a Licensed Practical Nurse (LPN) explained all cabinets and refrigerators must remain locked and inaccessible because confused residents may ingest chemicals and food and non-food items. The LPN revealed there was one resident who was known for pulling on the cabinets, getting and ingesting sugar packets. On 09/23/2025 at 8:22 AM, CNA2 identified the resident the LPN was referring to as Resident 200 who was often seen opening and rummaging through the cabinet containing condiments and often ate the sugar packets. CNA2 confirmed there were more than 200 packets of sugar, more than 100 packets of artificial sweetener, a box of salt packets and a variety of condiments which were supposed to be inaccessible given the unit's resident population.	F0689	mechanisms on cabinets and refrigerators on the memory care unit for 12 weeks, then transition to monthly inspections to ensure all equipment remains in good working order and properly secured. The DON/designee will review refrigerator safety logs 3x a week x12 weeks. Any discrepancies will be addressed immediately, with re-education and corrective action as needed. Compliance and trends will be monitored and reviewed during the facility's monthly QAPI meetings. Completion date: December 5, 2025	
F0813 SS = D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F0813	F0813 Personal Food Policy The facility will maintain a policy governing the use and storage of	

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F0813 SS = D	Continued from page 13 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the temperature, dating, and labeling of food in residents' personal refrigerators were properly monitored for 3 of 51 sampled residents (Resident 1, 2 and 136) and one unsampled resident (Resident 125). The deficient practice had the potential to lead to foodborne illness. Findings include: 1) On 09/25/2025 at 10:45 AM, a Licensed Practical Nurse (LPN), indicated Certified Nursing Assistances (CNAs) were responsible for cleaning the resident personal refrigerators weekly and on weekends. The LPN observed Resident 2's personal refrigerator and agreed the refrigerator was dirty and freezer had a buildup of ice and needed to be cleaned. The LPN explained, food brought in by family members must be stored in the refrigerator for no more than three days (72 hours). The LPN verbalized if the food remained beyond the expiration date, it was to be discarded by the CNAs. The LPN stated food must be dated either by staff or by the family. The LPN reiterated food items with manufacturer expiration dates must be discarded when expired. 2) An LPN verified the temperature in R125's personal refrigerator was 50 degrees Fahrenheit. The temperature in R1's refrigerator was 42 degrees Fahrenheit. On 09/25/2025 at 11:14 AM, Certified Nursing Assistant 6 (CNA6) indicated CNAs were responsible for checking and cleaning residents' personal refrigerators if they were dirty. The CNA was unsure who was responsible for checking the refrigerator temperatures and had not checked the temperature. The CNA explained food brought in by family members must be dated and remained in the refrigerator for three days. After three days the food was discarded. The CNAs informed the resident the food had expired before the food was discarded. On 09/25/2025 at 11:19 AM, Certified Nursing Assistant 7 (CNA7) verbalized CNAs checked and cleaned residents' personal refrigerators daily. The CNA explained all food must be dated and labeled with an expiration date of 72 hours (three days). The CNA acknowledged before discarding any food the CNAs explained to the residents why the food had to be discarded. CNA7 revealed housekeeping was responsible for checking the refrigerator temperatures and logging them.			F0813	foods brought in by family members and other visitors to ensure safe, sanitary handling, storage, and consumption. Residents (R1), (R2), (R136) and (R125) continue to reside in the facility and are receiving care according to physician's orders and plan of care. Resident (R125)'s refrigerator was relocated in room to a secure location. A house-wide audit of all resident room refrigerators was completed to assess cleanliness, temperature regulation, and the presence of expired or unsafe food. Any expired food was discarded, and refrigerators were cleaned as needed. A daily refrigerator monitoring checklist was implemented for housekeeping staff to ensure that resident room refrigerators are checked each day for cleanliness (both interior and exterior), expired or improperly stored food, and proper functioning, including temperature control. Housekeeping staff are responsible for cleaning the inside and outside of each resident refrigerator and reporting any issues to nursing or maintenance. Refrigerator monitoring was added to the existing Angel Round form, which is completed by management on a bi-weekly basis to ensure compliance with environmental		

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F0813 SS = D	Continued from page 14 On 09/25/2025 at 11:25 AM, Certified Nursing Assistant 8 (CNA8) was not aware who was responsible for checking residents' personal refrigerators. CNA8 did not know who was required to date the food when it was brought in by family members or from the outside, especially if they had not already had date, or a label. CNA8 acknowledged was food should remain in the refrigerator for three days. On 09/25/2025 at 11:30 AM, Certified Nursing Assistant 9 (CNA9) verbalized CNAs were responsible for checking residents' personal refrigerators for expired or spilled food. CNA9 explained that food would be discarded after three days. CNA9 indicated CNAs were responsible for labeling food with the date if the family or resident had not already done so. CNA9 was unsure who was responsible for checking the refrigerator temperatures. On 09/25/2025 at 11:45 AM, a housekeeper mentioned housekeeping checked residents' personal refrigerators daily and cleaned both the inside and outside each day. The housekeeper added if any food appeared to be spoiled, housekeeping would discard it with the permission from the resident. The housekeeper was not responsible for dating the resident's food. On 09/25/2025 at 11:55 AM, a Housekeeping and Laundry Manager indicated housekeeping staff checked residents' refrigerators daily for spilled food or if it was dirty and performed a full cleaning once a month due to having 24 rooms to clean. The Housekeeping and Laundry Manager explained resident personal refrigerator temperatures were checked daily but not documented in a logbook. The Housekeeping and Laundry Manager noted if a resident refused staff access to clean the refrigerator, they would not proceed. The facility had no specific policy related to residents' personal refrigerators. On 09/25/2025 at 11:00 PM, Director of Nursing (DON), indicated all the staff was responsible for cleaning residents' personal refrigerators, and was a team effort. The DON explained food brought in by families must be dated and stored for no longer than 72 hours, the same policy as the facility's main refrigerators. The DON added that the resident personal refrigerator temperatures were logged by maintenance staff and recorded in their logbook. The DON confirmed the personal refrigerator for R125, R1, R2 and R136 needed to be cleaned, food needed to be dated, and expired food should have been discarded. The DON acknowledged			F0813	and safety standards across all resident rooms. The daily housekeeping checklist is reviewed by the Housekeeping Supervisor to confirm completion and address any concerns promptly. The Angel Round form, now including refrigerator checks, is reviewed bi-weekly by the Administrator/designee for oversight and follow-up. All housekeeping staff received in-service training on the new daily refrigerator monitoring checklist, including proper cleaning techniques, identifying expired or improperly stored food, and reporting procedures for any issues discovered on <u>10/08/2025</u> and training will be ongoing. New housekeeping staff will be educated on this process during orientation. The DON and Maintenance Director were also educated on their roles in responding to reported refrigerator concerns to ensure timely resolution on <u>10/30/2025</u> and training will be ongoing. Management staff were trained on completing the updated Angel Round form with refrigerator monitoring included and on follow-up procedures. New employees will receive training on the refrigerator monitoring and safety procedures during their orientation and onboarding process to ensure consistent compliance. Ongoing education will be provided as needed based on monitoring outcomes and during annual competency reviews.		

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F0813 SS = D	Continued from page 15 expired food poses a risk of causing foodborne illness. R125's personal refrigerator was found to be unsecured and unsteady on top of the resident's chest of drawers. The DON noted that if the refrigerator door was pulled forcefully, the unit could tip over, presenting a safety hazard. On 09/25/2025 at 12:00 PM, the Administrator confirmed the facility did not have a policy specific to residents' personal refrigerators. The Administrator indicated the existing policy pertained to food brought in by family members or visitors. On 09/25/2025 at 2:00 PM, the Maintenance Director indicated maintenance staff did not monitor the temperatures of residents' personal refrigerators. The Maintenance Director explained maintenance, checked the facility's refrigerators and addressed repairs as needed. Maintenance provided thermometers for use in residents' personal refrigerators. On 09/25/2025, at 3:17 PM, the Administrator, indicated family members were expected to label and date food items placed in residents' personal refrigerators, as they were the ones bringing the food for their loved ones. On 09/26/ 2025 at 8:14 AM, a Director of Dining Services indicated food stored in residents' personal refrigerators should be maintained at a temperature between 30 degrees Fahrenheit and 40 degrees Fahrenheit. The facility policy titled "Foods Brought by Family/Visitors", revised October 2017, documented food brought into the facility by family/visitors that was left with the resident to consume later, would be labeled and stored appropriately and the nursing staff would discard perishable foods on or before the use by date. The facility utilized safe food handling guidelines which documented food should be kept at 40 degrees Fahrenheit or cooler.	F0813	The House keeping Supervisor will audit six resident refrigerators weekly for 12 weeks, then transition to monthly audits thereafter to ensure continued compliance. Residents and families were sent a letter regarding the guidelines of personal refrigerators. Results from the daily housekeeping checklist, nurse management audits, and Angel Round forms, including any compliance findings, will be reported and reviewed during monthly QAPI meetings to identify trends, determine if further action or staff re-education is needed, and to ensure sustained adherence to refrigerator safety protocols. Completion date: December 5, 2025	
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F0921	F0921 Safe/Functional/Sanitary/Comfortable Environment The facility will continue to provide a safe, functional, sanitary, and comfortable	

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F0921 SS = D	Continued from page 16 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure cabinet and refrigerator locks were in working condition in the specialty care unit. The deficient practice had the potential to pose a safety risk to residents with dementia who resided in the unit. Findings include: On 09/23/2025 at 8:10 AM, an inspection of the specialty care unit revealed two wooden cabinets and a staff refrigerator with broken locks. The Director of Maintenance turned the locks and confirmed the cabinet and refrigerator locks were broken. Certified Nursing Assistant 1 (CNA1) indicated the first cabinet contained food condiments and plastic cutlery while the second drawer contained three opened bottles of dish soap. On 09/23/2025 at 8:15 AM, CNA1 explained the specialty care unit housed 17 residents with a diagnosis of dementia and all cabinets and refrigerators must be kept secure and contents inaccessible for safety reasons. On 09/25/2025 at 8:44 AM, a revisit to the specialty care unit revealed the first cabinet was missing a drawer face and had no knob while the bottom drawer had a broken lock which made contents easily accessible by staff and residents. The locks on the second drawer and the staff refrigerator remained broken. On 09/25/2025 at 8:46 AM, CNA3 verbalized the broken cabinet, and locks had been broken for almost one month and CNA3 recalled running into one of the maintenance staff members and mentioned the issues in the unit. CNA3 acknowledged not completing a maintenance work order form for the broken equipment. On 09/25/2025 at 8:50 AM, R200 was observed approaching the first cabinet and pulled the handles but was redirected by staff before accessing the cabinet contents. On 09/25/2025 at 8:52 AM, a Licensed Practical Nurse (LPN) indicated cabinet and refrigerator locks had been broken for nearly a month. The LPN provided the Maintenance Work Request Log binder which revealed the unit did not have any outstanding request for repair. The LPN explained the cabinet and refrigerator locks were broken when the LPN returned from vacation, so the LPN assumed someone else put in a work order for			F0921	environment for residents, staff and the public. The 2 cabinet locks and the broken drawer face were repaired. The staff refrigerator lock was repaired. The unlocked resident refrigerator was secured immediately with existing lock. A Refrigerator/Cabinet Safety Check Log was implemented, requiring nursing staff to confirm the locked status of refrigerators and cabinets on the memory care unit hourly. Memory care staff received in-service training on the procedure for reporting equipment issues to maintenance and, if needed, following up with the administrator on 12/5/2025 and training will be ongoing. The Director of Maintenance/ designee will conduct weekly inspections of cabinets and refrigerators on the memory care unit for 12 weeks, then transition to monthly inspections to ensure all equipment remains in good working order and properly secured. The DON/designee will review refrigerator safety logs 3x a week x12 weeks. Any discrepancies will be addressed immediately, with re-education and corrective action as needed. Compliance and trends will be monitored and reviewed during the facility's monthly QAPI meetings. Completion date: December 5, 2025		

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NAME OF PROVIDER OR SUPPLIER OASIS NURSING & REHAB OF GREEN VALLEY				STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELMAR GARDENS DRIVE , HENDERSON, Nevada, 89074			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0921 SS = D	Continued from page 17 repair. On 09/25/2025 at 11:20 AM, the Director of Maintenance and another maintenance staff member explained each nurses' station had a maintenance binder where nursing staff could document request for repair of equipment. The maintenance staff explained there was one method for requesting repair of equipment and this was by using the maintenance log. Verbal requests were not acceptable because it would be easy for maintenance to forget especially when the request was mentioned while the maintenance was busy with another task. The Director of Maintenance indicated most requests were repaired within 24 hours from receipt unless and confirmed there were no work requisitions received by maintenance staff regarding the broken cabinet and locks. The facility policy "Homelike Environment", revised February 2021, documented residents were to be provided a safe environment.			F0921			