STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS NURSING & REHAB OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89074

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 05/22/2025, 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 200. The sample size was five. There were two complaints and one Facility Reported Incident (FRI) investigated: Substantiated: 1. Complaint NV00073304 was substantiated. (See Tag F755) 2. FRI NV00073489 was substantiated. (See Tag F600) Unsubstantiated: 3. Complaint NV00073571 could not be substantiated. No regulatory deficiencies could be identified. The investigation of complaints and FRIs included: Observation of the physical appearance for residents, activity observation, and a tour of the facility. Interviews were conducted with residents, Certified Nursing Assistants, Licensed Nurses,	F 000	**Public Notice Disclaimer:** The plan of correction is signed and submitted as required under State and Federal Law. 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. 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. 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. RECEIVED JUN 1 2025 BUREAU OF HEALTHCARE QUALITY & COMPLIANCE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Caroline Dooling-Boyden	Administrator	06/13/2025

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.

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F 000	Continued From page 1 Social Workers, Maintenance Workers, the Director of Nursing, the Infection Preventionists, the Activity Director, the Pharmacist, the Maintenance Director, the Housekeeping Supervisor, and the Administrator. Clinical Record review of five records, which included the residents of concern. Document review included facility policy and procedures, shower schedules, medication error reports, the facility's water management plan and related documents. The findings and conclusions of any investigation by the Division of Public and Behavioral Health 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:	F 000	Continued from page 1 The facility submits this plan of correction with the intension 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.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		

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F 600	Continued From page 2 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review, the facility failed to ensure a resident was kept safe from abuse for 1 of 5 sampled residents (Resident 4). The deficient practice had the potential for the resident to experience emotional distress and physical harm. Findings include: Resident 4 (R4) R4 was re-admitted to the facility on 02/11/2024 with diagnoses including cerebral palsy, depression, anxiety disorder, and diabetes mellitus. The resident had a brief interview for mental status (BIMS) evaluation with a score of 15, denoting the resident's cognition is intact. Resident 5 (R5) R5 was admitted to the facility on 07/12/2024 with diagnoses including traumatic subdural hemorrhage, chronic respiratory failure, dementia, and depression. The resident had a brief interview for mental status (BIMS) evaluation with a score of 15, denoting the resident's cognition is intact. The facility reported incident (FRI) dated 02/19/2024 documented the following: -On 02/19/2025 at approximately 1:45 PM, R4 reported to the Director of Social Services (DSS) and the Administrator that in December of 2024,	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 3 R5 had touched R4's chest under the shirt. R4 stated R5 did this without permission. - R5 was interviewed and admitted to touching R4's chest one time and knew it was wrong and would never do it again. -Conclusion: The allegation of abuse by R5 against R4 was substantiated. The police department was contacted and responded to the notification of the incident. The police stated R5 had reached down R4's shirt and touched the chest. However, due to circumstances, lack of witness, and their stories not exactly lining up, no arrest would occur. Instead, a report would be filed with the District Attorney for determination if a warrant would be issued. The DSS investigative notes documented R4 had not told any staff about the situation, but did tell a relative. The relative confirmed R4 had told the relative of the situation but was not sure why the resident had not let the facility know of the allegation. Skin Assessments dated 12/03/2024, 12/06/2024, 12/13/2024, 12/24/2024, 12/27/2024, and 12/31/2024 documented R4 had head-to-toe skin checks performed to check for any skin issues. On 12/13/2024, a skin rash on the upper left chest was notated. All other dates documented clear skin. R4 had no complaints of pain or discomfort in the chest area during December 2024. A behavioral Care Plan dated 01/24/2025 documented R5 was making sexual comments toward others. Interventions included praising good behaviors, positive feedback, education on	F 600		

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F 600	Continued From page 4 inappropriate behaviors, and to minimalize potential behaviors. A behavioral Care Plan revised on 01/24/2025, documented R4 was making false accusations and having physical altercations toward others. Interventions included anticipating resident needs, coping strategies, education on inappropriate behaviors, and to divert attention. Social Services progress notes dated 02/19/2025 documented R5 was no longer able to eat in the dining room and had to eat in the Unit one dining area, was not allowed to participate in group activities and was being put on one-to-one activities and was no longer allowed to visit unit four. Nursing progress notes dated 02/20/2025 documented R5 was placed on visual checks every 15 minutes to monitor the resident's behaviors. Social Services progress notes dated 02/20/2025 documented R5 had been moved from the 900 hall to the 500 hall to put more space between R4 and R5. On 05/22/2025 at 2:05 PM R4 stated this incident happened a while ago. R4 said does not think about the incident anymore as R5 was moved to another facility in a neighboring city. R4 stated R5 touched the resident inappropriately on the chest. R4 reported no psychosocial harm from the incident and reported was also not experiencing any emotional distress from the incident The facility policy titled Abuse, Neglect and Exploitation, Freedom From revised 09/2022,	F 600		

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F 600	Continued From page 5 documented it is their policy to maintain a living environment where residents are free from threat or occurrence of harassment, abuse, neglect, corporal punishment involuntary seclusion and misappropriation of property. During the onsite investigation on 05/22/2025, the facility's correction of the past non-compliance related to the incident occurred as evidenced by: -Observation of resident interactions were respectful and courteous. -Interviews with residents revealed they were happy with staff and were treated in a polite manner. - CNA's and Licensed Nurses indicated the facility provided continuing education regarding Abuse and Neglect. -R5 was separated from R4 with R5 being continuously monitored. -R5 was discharged to another long-term care facility on 02/24/2024. -Review of the facility's training records corroborated the staff interviews regarding training.	F 600		
F 755 SS=D	Facility Reported Incident #NV00073489 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755	**F-755** **Pharmacy Srvcs/Procedures/ Pharmacist/ Records** The facility will continue to provide pharmaceutical	

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F 755	Continued From page 6 them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and document review, the facility failed to ensure the wrong medication was not administered to a resident for 1 of 5 sampled residents (Resident 3). The deficient practice placed the resident at risk for kidney transplant complications. Findings include:	F 755	**Continued from page 6** services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. Resident (R3) continues to reside in the facility and is receiving prescribed medications according to physician's orders and plan of care. An assessment was completed by the attending provider to evaluate the residents' condition and ensure continued alignment with the plan of care. It was determined that no harm resulted from the medication error. At the facility's request, the pharmacy bolded the medication descriptions on the bubble packs. This safety enhancement was implemented to improve readability, support accurate medication administration, and help staff	

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F 755	Continued From page 7 Resident 3 (R3) R3 was admitted on 02/24/2022 and readmitted on 04/09/2025 with diagnoses including end stage renal disease (ESRD), and kidney transplant status. A physician order dated 02/24/2022 documented to give Tacrolimus 0.5 milligram (mg), one capsule (a form of oral medication made of a gelatin or plant-based shell filled with powder, liquid, or granules) by mouth once a day for kidney transplant. (Tacrolimus- an anti-rejection medication prescribed to patients who receive organ transplant for the purpose of suppressing immune response). A medication error report dated 01/25/2025 revealed R3 was administered Cialis 5 mg tablet (a form of oral medication in solid form of compressed powder which may be coated, scored, or split) on 01/18/2025, 01/19/2025, 01/20/2025, 01/21/2025, 01/22/2025, and 01/23/2025 (six doses). According to the report, R3 was erroneously given Cialis instead of Tacrolimus due to pharmacy mislabeling a medication bubble pack. The medical record lacked documented evidence R3 was prescribed Cialis (a medication primarily used to treat erectile dysfunction and benign prostatic hyperplasia or BPH). On 05/22/2025 at 09:30 AM, a Licensed Practical Nurse (LPN1) confirmed administering Cialis to R3 on 01/19/2025, 01/20/2025, 01/21/2025, 01/22/2025, and 01/23/2025 by mistake because the medication pack was mislabeled. LPN1 verbalized medications were administered based	F 755	**Continued from page 7** promptly identify any potential labeling discrepancies. The DON/designee reeducated all nursing staff on the facility's medication administration policy, emphasizing the Rights of Medication Administration and the importance of verifying that the medication description accurately matches the medication and the label. New nurses will be educated on this process during orientation. Ongoing training will occur annually and as needed. The Rights of Medication Administration have been printed and prominently posted on all medication carts to serve as a visual aid and reinforce safe medication practices. A house-wide audit was conducted to ensure all medication descriptions were confirmed to match the pills in the bubble packs,	

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F 755	Continued From page 8 on the five rights of medication administration including right patient, right drug, right dose, right route and right time. LPN1 explained medications were verified by looking at the label on the medication package and ensuring it was a medication ordered by physician and for the intended resident. LPN1 reviewed photo documentation of a medication bubble pack containing yellow tablets labeled as Tacrolimus 0.5 mg capsule with R3's sticker label. LPN1 acknowledged the failure to recognize the bubble pack contained medication in tablet form instead of capsule form. The LPN could not speak to why the mislabeled medication was not questioned until after the sixth dose. On 05/22/2025 at 11:30 AM, a Licensed Practical Nurse (LPN2) verbalized the medication would be verified by comparing the physician order in the electronic health record (EHR) to the label on medication card, and ensuring the medication was dispensed to the intended resident using name and photograph in the EHR. During medication pass the nurse would explain each medication to the resident. On 05/22/2025 at 12:38 PM, the Director of Nursing (DON) indicated being familiar with R3's medication error wherein the investigation revealed the pharmacy erroneously labeled a medication pack of Cialis as Tacrolimus in R3's name. The DON acknowledged LPN1 administered Cialis instead of Tacrolimus to R3 on 01/19/2025, 01/20/2025, 01/21/2025, 01/22/2025, and 01/23/2025. The DON indicated LPN3 who was assigned to R3 on 01/24/2025, noticed the	F 755	**Continued from page 8** and pharmacy labels were thoroughly reviewed for accuracy. The DON/Designee will audit 4 resident medication cards weekly for 12 weeks to ensure the medications match the description on the bubble pack. **Date of Compliance: June 30, 2025**	

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F 755	Continued From page 9 Tacrolimus presented as tablet form and reported the discrepancy to management. The DON indicated the pharmacy confirmed R3's medication bubble pack was mispacked with Cialis tablet instead of Tacrolimus capsule labeled with R3's name. The DON indicated the order should have been clarified based on the label identifying medication as a capsule with a tablet being in the bubble pack. The DON verbalized nurses assigned to R3 should have identified the error before R3 received the first dose on 01/18/2025. On 05/22/2025 at 1:35 PM, the Consultant Pharmacist indicated when medications were supplied from the pharmacy, a technician or pharmacist would pack the medications and apply the label. The Pharmacist would have the ultimate responsibility to ensure the medication pack was accurate prior to sending to facility. The Consultant Pharmacist revealed the medication should be verified several times by the pharmacy and facility prior to administration. On 05/22/2025 at 2:08 PM, a Registered Nurse (RN) at R3's dialysis clinic indicated being R3's primary nurse since R3's admission on 02/07/2022. The RN explained R3 underwent a kidney transplant in 2013 until the transplanted kidney started showing signs of rejection, specifically, kidney function had significantly declined making dialysis (renal replacement therapy) necessary. The RN indicated being aware R3 was on the anti-rejection medication Tacrolimus which the nephrologist wanted the resident to continue taking because the transplanted kidney had not been removed from the resident and could initiate an immune	F 755		

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F 755	Continued From page 10 response. The facility policy titled Administration Procedures for All Medication (revised November 2011) documented to review the five rights of medication three times prior to giving medication. Check the label against the order on the medication administration record. The facility policy titled Medication Ordering and Receiving from Pharmacy (revised November 2011) documented improperly or inaccurately labeled medications were rejected and returned to the dispensing pharmacy.	F 755		
F 880 SS=E	Complaint NV00073304 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880	**F-880 Infection Prevention & Control** The facility will continue to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility's correction of past non-compliance will continue, as evidenced by the ongoing completion and documentation of activities outlined in the Water Management Plan on a weekly,	

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F 880	Continued From page 11 arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880	**Continued From Page 11** monthly, quarterly, semi-annual, and annual basis. The facility has contracted an outside vender to develop a new Legionella Water Management Program for the facility water systems. The facility will continue to conduct quarterly reviews of its water management program and update, as necessary. The Administrator reeducated the Maintenance Director on the importance of thoroughly documenting all items on the Water Management Program checklist. Additionally, the Maintenance Director will submit all of the completed documents and checklists to the Administrator for review and storage on a weekly basis. **Date of Compliance: June 30, 2025**	

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F 880	Continued From page 12 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the water management plan was enforced. Findings include: During a complaint investigation, it was determined the facility had not been following the facility policy titled, "Legionella Water Management Program", dated 1/27/2019. The policy contained a checklist of items to inspect, the frequency to inspect them, and how to inspect the items. The checklist documented, "Record All Actions Taken in Your Water Management Plan Binder - Section 9". On 5/22/2025 at 10:30 AM, the Administrator and Maintenance Director explained the facility became aware of a possibility of Legionella in the building's water system when representatives from Southern Nevada Health District (SNHD) came to the facility on 6/18/2024. The facility was informed two prior residents had tested positive for Legionella and SNHD and a representative from Health Care Quality and Compliance (HCQC) were at the facility to consult with the facility's team to ensure safety. The Maintenance Director explained there was little documentation of testing performed between the establishment of the facility's Water Management Program, and the visit from SNHD on 6/18/2024.	F 880		

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	295041	A. BUILDING _____ B. WING _____	C 05/22/2025

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F 880	Continued From page 13 The prior residents that had subsequently tested positive for Legionella were Resident #1 and Resident #2: Resident #1: Resident #1 was admitted on 12/16/2023, with diagnoses that included acute and chronic respiratory failure, chronic obstructive pulmonary disease, pulmonary fibrosis, Guillain Barre syndrome, COVID, dependence on supplemental Oxygen, history of tracheostomy, and hypercapnia. On 3/10/2024 at 5:30 PM, Resident #1's SpO2 was 85% on three Liters Per Minute (LPM) of Oxygen. A DuoNeb nebulizer treatment was administered, but was temporarily effective, and the resident's SpO2 decreased to 85%. A Combivent nebulizer was administered and was ineffective. The resident's SpO2 was 85% on 4 LPM of Oxygen. 911 was called, and the resident was transferred to the emergency department of an acute care facility. Resident #1 did not return to the Skilled Nursing Facility, and no subsequent documentation was available. Resident #2: Resident #2 was admitted on 1/30/2023 with diagnoses that included acute and chronic respiratory failure, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure, and chronic kidney disease. On 6/5/2024 at 1:44 PM, the resident was transported via	F 880		

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F 880	Continued From page 14	F 880		

stretcher for persistent, productive cough post antibiotic treatment. The resident was admitted to an acute care facility.

Medical records from the receiving acute care facility indicated on 6/7/2024 at 12:30 AM, Resident #2 had a urine test, the results of which were "Presumptive Legionella pneumophila, serogroup 1 Antigen POSITIVE". On 6/9/2024 at 5:57 PM, a nasopharyngeal swab result was "Legionella species by Qualitative PCR : Not Detected".

Resident #2's Infectious Disease Consult, dated 6/7/2024, indicated the resident was on 2 LPM via nasal cannula and SpO2 was 100%. The resident was on antibiotics including piperacillin-tazobactam and doxycycline. The plan was to discontinue the antibiotics and introduce Azithromycin. The Physician documented to inform the health district of the positive Legionella result.

Resident #2's Discharge Summary from the acute care facility, dated 6/16/2024, documented the resident feels much better and was being transferred to another facility.

Resident #2's facesheet indicated Resident #2 was readmitted on 8/27/2024. The resident expired on 9/7/2024 at 11:50 AM.

On 5/22/2025 at 9:30 AM, the Director of Nursing (DON), explained had previously been the facility's Infection Preventionist during the remediation of the water system made through SNHD and HCQC. The DON explained was aware these two residents had been transferred to other facilities and had tested positive for

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F 880	Continued From page 15 Legionella. The two residents had testing to determine the source of the pathogen, but testing was inconclusive and could not be determined. On 05/22/2025, the Administrator provided a copy of the Legionella Water Management Program (LWMP), dated 01/27/2019. The LWMP was reviewed and found to be adequate for the type of facility and resident population. Specific issues or concerns within the plan were noted: -The plan was dated 01/27/2019. No evidence was provided to indicate the LWMP had been reviewed periodically. - The LWMP included a list of actions designed to mitigate the presence of legionella in the water. The facility staff were to complete and document certain activities on weekly, monthly, quarterly, semi-annual, and annual basis. Activities included but were not limited to temperature checks, flushing of pipes and fixtures, cleaning of systems such as ice machines, eye washes, and therapy pool. - Included in the LWMP was a water system flow diagram specific for this facility. The diagram was not clear in presenting the water flow within the facility. - The LWMP also had a diagram indicating the locations of where control measures should be taken periodically. - The LWMP had a list of items the facility was to check weekly, monthly, quarterly, etc. The list was not written specifically for this facility but was written for a facility in Missouri. On 05/22/2025, the Maintenance Director (MD) was interviewed concerning the facility's LWMP. When asked for documented evidence that the	F 880		

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F 880	Continued From page 16 LWMP had been implemented as far back as 2019, the MD explained the facility had conducted some of the activities but there was no documentation to support allegation of compliance. The MD did provide documented evidence that some of the indicated activities were being documented, but the documentation began in June 2024 when the facility was notified by the local health department, the facility may have active legionella on the property. On 05/22/2025, the Administrator confirmed the LWMP had not been reviewed except when the facility had been notified about possible legionella concerns within the facility June of 2024. The Administrator further explained, the facility had been notified in June of 2024 concerning possible cases of legionella coming from their facility by the local health department. Water testing for legionella had been accomplished in June and July of 2024 that provided verification some samples were positive for legionella. A consultant was hired, and mitigation steps were activated starting in June 2024. Flushing of water systems, changing of filters, cleaning of faucet equipment and hyperchlorination was accomplished. Documentation was provided indicating those activities had been accomplished. On 05/22/2025, the Administrator provided a copy of water analysis for April 2025. Legionella testing was conducted, and no legionella was detected. The Administrator indicated in an interview on 05/22/2025 that the facility was in the process of developing an updated LWMP through a new vendor. No timeline was provided.	F 880		

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