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	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis Nursing & Rehab of Green Valley	100 Delmar Gardens Drive Henderson, NV 89074

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: 1) Resident 169 (R169) was admitted on [DATE] 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 [DATE], and readmitted on [DATE], 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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 [DATE] 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 Date 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 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [ROOM NUMBER]B from 03/27/2025 to 05/08/2025, and room [ROOM NUMBER]B from 05/08/2025 to 06/01/2025.The facility document titled Preferred Shower Schedule for the 200-hall documented 203B was to receive showers on day shift Wednesday and Saturday. room [ROOM NUMBER]B 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 [DATE] 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. 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

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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)

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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 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 [DATE] and readmitted on [DATE], 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 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 [DATE], 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 [DATE].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.A Hospital Discharge summary dated [DATE], 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 [DATE] 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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.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 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

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 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 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.