STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035276	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis Pavilion Nursing & Rehabilitation Center	161 West Rodeo Road Suite 1 Casa Grande, AZ 85122

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to protect the residents' (#1 and #63) rights to be free from abuse of another resident (#149 and #15). The deficient practice could result in further abuse of residents and appropriate action not take. Findings include: Regarding resident #1 and resident #149 -Resident #1 (alleged victim) was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure, Parkinson's disease with dyskinesia, major depressive disorder, chronic obstructive pulmonary disease, and rheumatoid arthritis. The activities of daily living (ADL) care plan initiated on November 28, 2022 included that the resident required assistance due to weakness, congestive heart failure, Parkinson's disease, and restless leg syndrome. Interventions included assist with ADLs as needed. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating that the resident was cognitively intact. The MDS also indicated that the resident had not exhibited psychosis, behavioral symptoms, wandering, or rejection of care during the assessment period. A nursing note dated August 14, 2023 revealed that the resident #1 reported that that resident #149 threw a remote control at her; and that, the remote control hit her in the upper right shin and a large purple bruise was left from the remote control. A physician order dated August 14, 2023 revealed to monitor bruising on right upper shin one time a day for swelling for 5 days. The incident report dated August 14, 2023 included that resident #1 reported that resident #149 threw a remote control at her; and that, the remote control hit her in the upper right shin. The documentation also included that resident #1 sustained a large purple bruise from the incident; and, the resident was immediately removed from activities and assessed by a nurse. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another physician order dated August 15, 2023 included to monitor bruising to the right lower extremity for worsening and signs and symptoms of infection one time a day for swelling for 14 days. A physician order dated August 15, 2023 included an order for a stat x-ray for right leg pain. A case management note dated August 15, 2023 revealed that the long-term care case manager was notified via email that resident had bruise to right shin; and that, radiographs were ordered and treatment was in place. Review of a nurse practitioner psychiatric note dated August 16, 2023 indicated that resident was alert and oriented X 3, was cooperative per staff, and insight and judgment were good. -Resident #149 (alleged perpetrator) was readmitted on [DATE] with diagnoses that included blindness in the right eye, diabetes mellitus type 2, and amputation at knee level of right lower leg. Review of the care plan initiated on July 10, 2023 included that the resident had behavioral symptoms for impulsive decision making related to feeling sorry for himself and attention seeking related to life choices and have outburst behaviors. Interventions included to allow to express feelings and thoughts, extra staff assistance when abusive or resistive, keep environment calm and relaxed, remove from others when behavior is unacceptable, redirect with diversion activities and one to one supervision. The admission MDS assessment dated [DATE] revealed a BIMS score of 15 indicating that the resident had intact cognition. The MDS also revealed that the resident did not exhibit psychosis, behavioral symptoms, rejection of care, and wandering at the time of the assessment period. Review of the facility's self-report dated August 14, 2023 included that residents #1 and #149 were in the activities room. Per the documentation, resident #1 was watching television (TV) and resident #149 changed the TV station; and that, resident #149 thought he heard resident #1 said why do they had to watch that Indian show. The documentation included that resident #149 became upset, picked up the remote and threw it, hitting resident #1 in the right lower extremity. Per the report, both residents were separated immediately. The facility's final investigation included a witness statement dated August 18, 2023 from resident #1 who stated that she was speaking to an activities assistant when resident #149 took control of the remote and changed the channel to something native. Per the documentation, resident #1 asked the activities assistant if the residents had to keep watching the channel; and that, resident #149 then started coming towards resident #1 and called resident #1 a racist. It also included that the activities assistant had to physically stop resident #149 from coming at resident #1 after he threw the remote at her. The facility investigation also included a witness statement from another resident dated August 18, 2023. Per the documentation, resident #149 came into the activities room and immediately changed the channel to head banging music and turned the volume up; and that, the activities assistant asked him to turn the volume down in respect of other residents. It also included that resident #149 responded that everyone was racist and began yelling expletives. Further, the statement included that resident #149 then threw the remote at and started approaching resident #1; and that, the activities assistant asked resident #149 to leave and took resident #1 to the nurse's station. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the facility investigation revealed a witness statement dated August 14, 2023 from the Social Services Director (SSD/staff #250) who reported that an activities assistant wheeled a tearful resident #1 to the nurse's station; and that, the activities assistant informed her that resident #149 threw a remote control at resident #1's leg leaving an already visible bruise. Per the documentation, resident #1 reported to the SSD that resident #149 hit her for no reason; and that, resident #1 asked the activities assistant if they had to watch Native shows. It also included that resident #149 became upset and called resident #1 a racist; and that, resident #149 yelled expletives at her prior to throwing the remote at her leg. Further, the documentation included that resident #149 admitted to the SSD that he threw the remote at the table and it hit resident #1; and that, resident #149 was leaving AMA (against medical advice). Review of the facility's final investigation report dated August 18, 2023 revealed that the facility concluded that the allegation of abuse was substantiated since resident #149 threw the remote, hitting resident #1 in the leg which resulted in a bruise; and that, resident #149 left the facility AMA. Regarding resident #63 and resident #15 -Resident #63 (alleged victim) was admitted on [DATE] with diagnoses of Parkinsonism and anxiety disorder. A skin integrity care plan initiated on May 17, 2023 included that the resident was at risk for skin breakdown related to disease process, impaired mobility, and incontinence. Interventions included to address any incontinence care as needed, dietary consult, encourage or assist in repositioning, and observe skin daily during routing care, and report changes. A care plan initiated on May 17, 2023 revealed that the resident was on medication for anxiety. The goal was resident will have optimal benefit of medication without side effects. Interventions included to monitor for side effects and report changes to the doctor. The admission MDS assessment dated [DATE] revealed a BIMS score of 14 indicating that the resident was cognitively intact. The MDS also included the resident did not exhibit psychosis, behavioral symptoms, rejection of care or wandering during the assessment period. Review of a care plan revised on June 7, 2023 revealed that the resident required assistance for ADLs (activities of daily living) related to weakness and unsteady balance. Interventions included to assist with ADLs as needed. A case management note dated July 26, 2023 included the resident reported that her old roommate (resident #15) ran into her with an electric wheelchair; and that, resident #63 reported that she was unsure if resident #15 ran into her on purpose. Per the documentation, resident #63 also reported that this had occurred on more than one occasion with the most recent event happening yesterday; and that, resident #63 was sitting on the edge of the bed eating dinner when resident #15 backed up in her wheelchair bumping into her and hitting her knees. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social service note dated July 26, 2023 revealed that the Social Services Director (SSD) received a report from the unit nurse that resident #63 was receiving threatening statements and actions from her roommate. According to the documentation, resident #63 was assessed and moved to another unit for safety. The nursing note dated July 26, 2023 included that skin assessment was done; and that, resident #63 had a small indentation with small bruise under her right knee and her right knee hurts. Further, the documentation included that there was no open skin and that a call was placed to the provider with new orders noted. Review of the facility report dated July 26, 2023 revealed that resident #63 reported that resident #15 had been mean to her and bumped into her knees with the motorized scooter. The report noted that residents were separated and placed on different units as part of the intervention implemented following the event. The incident report dated July 26, 2023 included that resident #63 was bumped by a wheelchair which resulted in a small bruise on her right knee. -Resident #15 (alleged perpetrator) was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, major depressive disorder, and multiple sclerosis. A behavioral care plan initiated on February 7, 2023 revealed the resident had behavioral symptoms related to impulsive behavior. Interventions included to allow resident to express thoughts and feelings, extra staff assistance when abusive or resistive, and keep environment calm and relaxed. The quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating that the resident was cognitively intact. The MDS also included the resident was negative for psychosis, behavioral symptoms, wandering, and rejection of care. A nursing note dated July 26, 2023 revealed that the roommate (resident #63) reported that resident #15 had been mean, bumped into the roommate with the motorized scooter and told the roommate that she controlled the room. Per the documentation, the roommate (resident #63) stated that the resident told the roommate that no one would believe if the roommate told anyone about the incident. Further, the documentation included resident #15 bumped only one person with her chair; and that, resident #15 had used similar behaviors with previous roommates. Furthermore, the note included that resident #15 stated that she would like to be in her room by herself. Further review of the care plan did not include interventions to address resident's behavior to intimidate roommates or tendency to use wheelchair to bump into people. A social service note dated July 26, 2023 included that social services director (SSD) informed the resident's family/POA (Power of Attorney) regarding the altercation between the resident and her roommate; and that, the resident's family/POA expressed sympathy for the altercation and she would come in the facility to speak with the resident. Per the documentation, the resident's family/POA was informed that resident #15 will be moved to a different due to resident #15 being the aggressor in the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A case management note dated July 27, 2023 revealed resident #15 stated that she got along with her roommate (resident #63); and that, they never had an argument. It also included that resident #15 reported that she bumped into resident #63 on accident due to her not having enough room to maneuver the wheelchair; and that, she agreed to a room change for more space. Another Case Management note dated July 27, 2023 documented that resident #15 was transferred to another room in C-hallway with all her belongings. Review of the facility report revealed that on July 26, 2023, resident #63 reported to the nursing staff that resident #15 had been mean to her and bumped her knees with the motorized wheelchair. Per the documentation, resident #15 stated that she was trying to back up her motorized wheelchair and accidentally hit resident #63; and that, interventions post incident consisted of separating residents into different rooms on different halls. An interview with a certified nursing assistant (CNA/staff #166) was conducted on March 7, 2024 at 12:58 p. m. The CNA stated that staff use the care plan and the nurse guidance to identify residents with behaviors that increases their risk for resident to resident altercations. The CNA said that the interventions following a resident to resident altercation included deescalating the situation, separating and monitoring the residents. The CNA stated that staff were provided abuse training approximately twice a week via meetings, pamphlets, and as incidents occur; and that, staff reports instances/allegations of abuse to the Director of Nursing (DON) within 2 hours of the incident. An interview was conducted on March 7, 2024 at 1:09 p.m., with a Licensed Practical Nurse (LPN/staff #123) who stated that they are able to identify residents with behaviors that can potentially lead to resident to resident altercations by knowing the residents' baseline and observing behaviors. The LPN said that residents have behaviors and any little things that may trigger them; and that, they try to match up roommates as best possible and accommodate those changes and see if the situation was ideal. The LPN also said that they document on assessments/notes regarding psych and behavior; and, any issue that makes resident prone to resident to resident altercation was care planned. The LPN further stated that following a resident to resident altercation, the following interventions are put in place: separate residents, re-direct, removing residents them from the situation. The LPN also stated that staff were supposed to update the care plan following a resident to resident altercation; and, staff reports incidents/allegations of abuse to the DON as soon as possible. During an interview with the Assistant Director of Nursing (ADON/staff #58) conducted on March 7, 2024 at 1:38 p.m., the ADON said that her expectation was that abuse is stopped and the residents are separated and safe; and that, abuse is reported as soon as it is identified so that the facility can in turn report to the required outside agencies within 2 hours. Review of the facility policy titled Abuse and Neglect dated January 9, 2024 included that it is their responsibility to identify any resident whose personal history renders them at risk for abusing residents, and development of intervention strategies to prevent occurrence, monitoring for changes that would trigger abusive behavior, and reassessment of the intervention on a regular basis.