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	01/27/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on the clinical record, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#55) was assessed, monitored, and provided emergency response. The deficient practice could result in residents not receiving emergency treatment and could lead to physical and psychosocial harm. Findings include: Resident #55 was admitted to the facility on [DATE] with diagnoses that included altered mental status, chronic obstructive pulmonary disease, malignant neoplasm of the brain, type II diabetes, hemiplegia and hemiparesis affecting the left dominant side, and slurred speech. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 11 indicating the resident had a moderate cognitive impairment. The order summary included the following orders: -December 11. 2024, oxygen (O2) per nasal cannula (NC) to keep saturation greater than 90%: Check SATs every shift and as needed (PRN) every shift for vitals. -January 19, 2025 at 1:40 p.m., send the patient to the hospital. The order was created by a licensed practical nurse (LPN/staff #12). -January 19, 2025 revised at 5:33 p.m., send patient out emergent per the medical doctor (MD). Patient educated of the bed hold policy and given written notice of transfer. The order was revised by the Director of Nursing (DON/staff #10) -The order was created on January 20, 2025 by the (DON/staff #10), 1:40 p.m., on January 19, 2025 order by the Medical Director to send patient out emergent for altered mental status (AMS) per MD. Patient educated of the bed hold policy and given written notice of transfer. Review of the vitals revealed that the resident's oxygen level was taken on January 19, 2025 at 8:51 a.m. and was 93% via nasal cannula. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital transfer form dated January 19, 2025 at 2:00 p.m. revealed that the resident was transferred to hospital for low oxygen saturation. The oxygen level recorded was taken on January 19, 2025 at 8:51 a.m. and was 93% via nasal cannula. The report was called in by a registered nurse (RN/staff #15) to the emergency room and the ambulance transportation company on January 19, 2025, but the time and type of transfer was not documented. A nurse practitioner note late entry on January 28, 2025. Effective date January 19, 2025, revealed that the NP received a report from nursing that the resident was exhibiting AMS, tachycardia, hypotensive and desating to the 80's. The charge nurse was aware. The family doesn't wish for the resident to be on hospice. The patient was sent out 911 for a higher level of care. The resident was observed and this was a change of condition. An interview was conducted on January 28, 2025 at 11:18 a.m. with the Director of Nursing (DON/staff #10), who stated that she was not at the facility when the resident was transferred to the hospital on January 19, 2025 in the afternoon. She reviewed the progress notes and acknowledged that there was no documentation regarding the resident's change of condition (COC), vitals, stating that the MD had been notified, or whether the MD had ordered the resident transfer to the hospital emergent or non-emergent. Then she reviewed the vitals and stated that the resident's oxygen level was last taken on January 19, 2025 at 8:51 a.m. and was 93% via nasal cannula, but she had no way of knowing the oxygen level on the afternoon of January 19, 2025 when the resident was transferred to the hospital. She stated that the resident's pulse rate was 130 on January 19, 2025 at 2:30 p.m. and a normal pulse is under 100, so the resident's transfer to the hospital should have been emergent and the MD should have been notified of the COC. She stated that she is responsible for auditing hospital orders and the first order did not specify if the transfer was non-emergent or emergent, so she created a second order with a question mark because she wanted to know if the resident was transferred emergent or non-emergent, and the reason for the transfer. Once she found out that the resident had an altered mental status, she changed the transfer order to emergent. Then staff #1 reviewed the hospital transfer form dated January 19, 2025 at 2:00 p.m. and stated that she didn't know if 2:00 p.m. was the time the nurse started the form, called for transport, or the time the resident was transferred. She stated that the reason for transfer on the form was an abnormal pulse oximeter, which meant that the resident's oxygen saturation level was low, but the form did not indicate whether the transfer was emergent or non-emergent. She also acknowledged that that the form did not indicate the time the resident was transferred. Staff #10 left the interview and when she returned, she stated that the Administrator had spoken to the NP who stated that she was at the facility on January 19, 2025 and ordered for the resident to be transferred 911 and would be entering a progress note in the clinical record. An interview was conducted on January 28, 2025 at 1:50 p.m. with a second Director of Nursing (DON/staff #1), who stated that she contacted (RN/staff #15) on January 19, 2025 and staff #15 told her that the Nurse Practitioner (NP) was at the facility and instructed staff #15 to transfer the resident to hospital non-emergent. She stated that she received a message from the charge nurse (LPN/staff #12), saying the resident was sent out for being lethargic and desating. She stated that the message didn't indicate whether the transfer was emergent or non-emergent and had made a note to follow up with staff #12 because she had questions about how the resident was sent out to the hospital, but it was the weekend and by the time she came back to work, the resident had already been admitted . She stated that an order is supposed to be placed in the clinical record and a progress note is completed documenting the the condition of the resident, vitals, why the resident was transferred to the hospital, including the type and time of the transfer, and the physician's instructions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 28, 2025 at 2:05 p.m. with (RN/staff #15), who stated that the NP was at the facility. The charge nurse (LPN/staff #12) talked to the NP, was told to transfer the resident non-emergent, and he also completed the transfer paperwork for the resident. She stated that she took the resident's vitals, which should be in the clinical record and had no opinion as to whether the resident should be sent to the hospital emergent or non-emergent. An interview was conducted on January 28, 2025 at 2:10 p.m. with the charge nurse (LPN/staff #12), who stated that he remembered the resident, but doesn't remember anything about the transfer and doesn't remember if it was emergent or non-emergent. He stated that if he talked to the NP and sent the resident to the hospital, he would have completed a progress note. He stated that he wasn't assigned to the resident, but as a charge nurse may or would have helped. He stated that it was common sense, if the resident wasn't breathing, the resident would be an emergent transfer. The facility policy, Orientation for Transfer or Discharge (Emergent or Therapuetic Leave) states that for an emergency transfer or discharge to a hospital or other acute care institution, implement the following procedures: call 911 if the resident meets clinical/behavioral criteria per facility policy, or assist in obtaining transporation and notify the resident's attending physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observation, clinical review, interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#22) was provided wound care and services in accordance with professional standards of practice. Findings include: Resident (#22) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy, mild protein-calorie malnutrition, unspecified dementia, and chronic kidney disease. A care plan dated December 11, 2024 revealed that the resident was at risk for skin breakdown related to: -a pressure ulcer/deep tissue stage I, disease process and abnormal labs. -upon admission: left foot, a stage 2 closed blister, roof intact and not filled with fluid; there was no drainage and was resolved on December 24, 2024. -upon admission: sacrum/coccyx (superior), pressure ulcer stage I dark red non blanching. Skin was intact and peri wound appeared within normal limits (WNL). It was upgraded on December 24, 2024 to a pressure 3. Interventions included to address any incontinence care as needed, encourage and assist the resident in shifting of position every two hours while in bed and every one hour when up in chair, and wound care as ordered by the medical doctor. Review of the order summary revealed: -December 18, 2024, left heel (plantar): cleanse with normal saline (NS), pat dry. Apply betadine and let air dry, leave OTA. Monitor for worsening and report changes to provide. Every shift for wound care. -December 18, 2024, encourage use of low airloss mattress (LAL) for wound prevention/maintenance. -December 18, 2024, encourage/assist to apply barrier cream to buttocks, sacrum, and groin, every shift, and after episodes of incontinence or if shin concerns are present. Every shift for skin protection/care. -December 19, 2024, clean buttocks with NS and pat dry. Apply medihoney and a non stick dressing and secure in place. Monitor for signs and symptoms (S/S) of infection and report any concerns to the provider. Every day shift for wound care. -December 20 2024, encourage use of wedge and other support surfaces for positioning and offloading. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-December 20, 2024, wound consult for evaluation and treatment for the sacrum. -December 20, 2024, wound consult for evaluation and treatment , bilat buttocks and left heel. -January 13, 2024, send patient out non emergent family requested related to wound per medical doctor. Patient educated on bed hold policy and given written notice of transfer. -January 11, 2025, wound coccyx: cleanse wound with wound cleaner and gentle pat dry with sterile gauze. Apply zinc oxide to the wound bed and leave open to air. Every day shift. Note: an order cleanse sacral wound with wound cleanser, apply hydrogel ointment to wound bed, primary dressing: calcium alginate, facility choice of available sterile, non adhesive, moisture preserving dressing, secondary dressing: facility choice of available secondary dressing to secure primary layer in place was not in the order summary. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. It also included that the resident had two, stage I, pressure ulcers and one, stage II, pressure ulcer which was not present upon admission/entry or reentry. A physician's visit report dated December 24, 2024 revealed that the resident was being seen for a stage III sacral wound that was currently under treatment by wound care nursing at the time. The facility nursing staff has requested care and wound care consultation. Services will be rendered on their behalf due to the persistent complexities and resistance to healing of the the patient's wounds. -General notes: stage III sacral wound with noted eschar present and left heel with deep tissue injury (DTI). -Wound Assessment: wound #1 superior sacral is a stage 3 pressure injury pressure ulcer acquired on 12/24/2024 and has received a status of Not Healed. Initial wound encounter measurements are 11.66 cm length x 8.39 cm width x 0.2 cm depth, with an area of 97.827 sq cm and a volume of 19.565 cubic cm. Necrotic tendon, necrotic muscle and necrotic adipose are exposed. No tunneling has been noted. No sinus tract has been noted. No undermining has been noted. There is a Small amount of sanguineous drainage noted which has a Mild odor. The patient reports a wound pain of level 0/10. The wound margin is attached to wound base Wound bed has 1-25%, bright red, pink, firm, granulation, 1-25% adherent, yellow slough, 26-50% moist, black eschar. The periwound skin texture is normal. The periwound skin moisture is normal. The periwound skin color is normal. The temperature of the periwound skin is WNL. Periwound skin does not exhibit signs or symptoms of infection. -Procedures: wound #1 (Pressure Ulcer) is located on the superior sacral. A non-selective mechanical debridement was performed. Non-viable tissue was removed. The procedure was tolerated well with a pain level of 0 throughout and a pain level of 0 following the procedure. Post Debridement Measurements: 11.66 cm length x 8.39 cm width x 0.2 cm depth; with an area of 97.827 sq cm and a volume of 19.565 cubic cm. Post debridement stage noted as stage 3 pressure injury. -Wound orders superior sacral: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow-up in one week cleanse wound with wound cleanser apply hydrogel ointment to wound bed primary dressing: calcium alginate, facility choice of available sterile, non adhesive, moisture preserving dressing secondary dressing: facility choice of available secondary dressing to secure primary layer in place plan of care discussed with facility nursing staff Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated December 2024 did not reveal an order to cleanse sacral wound with wound cleanser, apply hydrogel ointment to wound bed, primary dressing: calcium alginate, facility choice of available sterile, non adhesive, moisture preserving dressing, and to use a secondary dressing: facility choice of available secondary dressing to secure primary layer in place was not in the order summary. An interview was conducted on January 27, 2025 with the wound nurse (LPN/staff #7). She reviewed A physician's visit report dated December 24, 2024 and stated that she was present when the wound provider evaluated the resident on December 24, 2024. She stated that during the visit, the sacral wound was open with slough and the provider upgraded the pressure ulcer from a stage I to a stage III. She also stated that during the visit on December 24, 2024, the provider ordered hydragel with calcium alginate to be applied daily and as needed, which was to be done by her and she would have documented the treatment was applied in the Treatment Administration Record (TAR). Staff #7 reviewed the resident's orders and stated that there was not an order for hydragel calcium alginate. Then, she reviewed the MAR and the TAR for December 2024 and stated that the treatment for hydragel calcium alginate was not on the MAR or the TAR, so there was no documentation of the treatment being done. Staff #7 stated that she must have forgotten to put the order for hydragel calcium alginate in, so it was not added to the MAR or TAR. She stated that there was a risk of the eschar not softening and the Medihoney should have been discontinued. An interview was conducted on January 27, 2024 at 1:05 p.m. with the Director of Nursing (DON/staff #1), who stated that treatments require a physician's order and when a nurse receives a verbal order, the order should be submitted and carried out as ordered. She stated that there is risk of the wound worsening if the ordered treatment is not done. She stated that it is the responsibility of the wound nurse to review the orders to ensure that nothing is forgotten. Review of the Wound Nurse General Job Description revealed that the wound nurse is responsible for rounding daily on residents with treatment orders to ensure the treatments are being completed and charted. The facility policy, Prevention and Treatment of Pressure Ulcers and Other Skin Issues states that any resident who has a pressure ulcer on admission has the appropriate treatment to promote healing and prevent any other pressure wounds.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Review of the clinical record, staff interviews, and the facility policy and procedures, revealed that the facility failed to document one resident's (#55) change of condition, that the physician was notified, the physician's instructions, and the type or time of the hospital transfer in the clinical record. Findings include: Resident #55 was admitted to the facility on [DATE] with diagnoses that included altered mental status, chronic obstructive pulmonary disease, malignant neoplasm of the brain, type II diabetes, hemiplegia and hemiparesis affecting the left dominant side, and slurred speech. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 11 indicating the resident had a moderate cognitive impairment. The order summary included the following orders: -December 11. 2024, oxygen (O2) per nasal cannula (NC) to keep saturation greater than 90%: Check SATs every shift and as needed (PRN) every shift for vitals. -January 19, 2025 at 1:40 p.m., send the patient to the hospital. The order was created by a licensed practical nurse (LPN/staff #12). -January 19, 2025 revised at 5:33 p.m., send patient out (non-emergent/emergent) for (?) per the medical doctor (MD). Patient educated of the bed hold policy and given written notice of transfer. The order was revised by the Director of Nursing (DON/staff #10) -The order was created on January 20, 2025 by the (DON/staff #10), 1:40 p.m., on January 19, 2025 order by the Medical Director to send patient out emergent for altered mental status (AMS) per MD. Patient educated of the bed hold policy and given written notice of transfer. Review of the vitals revealed that the resident's oxygen level was taken on January 19, 2025 at 8:51 a.m. and was 93% via nasal cannula. It did not reveal the oxygen saturation level when the resident had a change of condition in the afternoon on January 19, 2025. A nurse practitioner note late entry on January 28, 2025. Effective date January 19, 2025, revealed that the NP received a report from nursing that the resident was exhibiting AMS, tachycardia, hypotensive and desating to the 80's. The charge nurse was aware. The family doesn't wish for the resident to be on hospice. The patient was sent out 911 for a higher level of care. The resident was observed and this was a change of condition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 28, 2025 at 11:18 a.m. with the Director of Nursing (DON/staff #10), who stated that she was not at the facility when the resident was transferred to the hospital on January 19, 2025 in the afternoon. She reviewed the progress notes and acknowledged that there was no documentation regarding the resident's change of condition (COC), vitals, stating that the MD had been notified, or whether the MD had ordered the resident transfer to the hospital emergent or non-emergent. Then she reviewed the vitals and stated that the resident's oxygen level was last taken on January 19, 2025 at 8:51 a.m. and was 93% via nasal cannula, but she had no way of knowing the oxygen level on the afternoon of January 19, 2025 when the resident was transferred to the hospital. She stated that the resident's pulse rate was 130 on January 19, 2025 at 2:30 p.m. and a normal pulse is under 100, so the resident's transfer to the hospital should have been emergent and the MD should have been notified of the COC. She stated that she is responsible for auditing hospital orders and the first order did not specify if the transfer was non-emergent or emergent, so she created a second order with a question mark because she wanted to know if the resident was transferred emergent or non-emergent, and the reason for the transfer. Once she found out that the resident had an altered mental status, she changed the transfer order to emergent. Then staff #1 reviewed the hospital transfer form dated January 19, 2025 at 2:00 p.m. and stated that she didn't know if 2:00 p.m. was the time the nurse started the form, called for transport, or the time the resident was transferred. She stated that the reason for transfer on the form was an abnormal pulse oximeter, which meant that the resident's oxygen saturation level was low, but the form did not indicate whether the transfer was emergent or non-emergent. She also acknowledged that that the form did not indicate the time the resident was transferred. Staff #10 left the interview and when she returned, she stated that the Administrator had spoken to the NP who stated that she was at the facility on January 19, 2025 and ordered for the resident to be transferred 911 and would be entering a progress note in the clinical record. An interview was conducted on January 28, 2025 at 1:50 p.m. with a second Director of Nursing (DON/staff #1), who stated that she contacted (RN/staff #15) on January 19, 2025 and staff #15 told her that the Nurse Practitioner (NP) was at the facility and instructed staff #15 to transfer the resident to hospital non-emergent. She stated that she received a message from the charge nurse (LPN/staff #12), saying the resident was sent out for being lethargic and desating. She stated that the message didn't indicate whether the transfer was emergent or non-emergent and had made a note to follow up with staff #12 because she had questions about how the resident was sent out to the hospital, but it was the weekend and by the time she came back to work, the resident had already been admitted . She stated that an order is supposed to be placed in the clinical record and a progress note is completed documenting the the condition of the resident, vitals, why the resident was transferred to the hospital, including the type and time of the transfer, and the physician's instructions. An interview was conducted on January 28, 2025 at 2:05 p.m. with (RN/staff #15), who stated that the NP was at the facility. The charge nurse (LPN/staff #12) talked to the NP, was told to transfer the resident non-emergent, and he also completed the transfer paperwork for the resident. She stated that she took the resident's vitals, which should be documented in the clinical record. An interview was conducted on January 28, 2025 at 2:10 p.m. with the charge nurse (LPN/staff #12), who stated that he remembered the resident, but doesn't remember anything about the transfer and doesn't remember if it was emergent or non-emergent. He stated that if he talked to the NP and sent the resident to the hospital, he would have completed a progress note. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Change in a Resident's Condition or Status Policy states that the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.