

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Oasis Pavilion Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on staff interviews, review of clinical record and policy review, the facility failed to protect the rights of 2 of 4 residents sampled (#1, #2) to be free from verbal abuse between residents. The deficient practice could result in resident injury, psychological, or behavioral harm as well as continued resident to resident abuse. Findings include: Resident # 1, the alleged victim, was re-admitted to the facility on [DATE], with a diagnosis of noninfective gastroenteritis and colitis, unspecified protein deficiency, alcohol use, and dependence on renal dialysis. A comprehensive care plan initiated on April 30, 2025 revealed that Resident #1 had behavioral problems related to attention seeking. The care plan revealed that on June 22, 2025 Resident #1 stated that if someone is going to be physically aggressive or say derogatory remarks towards him he would defend himself. Interventions included not to use joking or kidding language when speaking with resident as this causes confusion or agitation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating he was cognitively intact. A comprehensive care plan revised on July 6, 2026 revealed that on July 5, 2026 Resident #1 had behaviors of being impulsive when someone is verbally aggressive with words. Interventions included allowing the resident to talk about his feelings and find a positive outcome. A Psychiatric progress note dated July 8, 2026, revealed that Resident #1 had described a recent incident involving interpersonal conflict with Resident #2 who was calling him names, which triggered frustration and a gesture toward Resident #2, though no physical aggression occurred. Resident # 2, the alleged perpetrator, was re-admitted to the facility on [DATE], with a diagnosis of encounter for palliative care, unspecified dementia severe without behavioral disturbance, and Parkinsonism. A comprehensive care plan initiated on July 1, 2026, revealed that Resident #2 had behavioral symptoms related to dementia and Parkinson's and can be impulsive at times. Interventions included keeping his environment calm and relaxed and monitoring and treating for constipation as needed. An admission MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating he was cognitively intact. A comprehensive care plan revised on July 6, 2026, revealed that on July 5, 2026 Resident #2 had attention seeking behavior related to calling his friends names when he is frustrated. Interventions initiated on July 6, 2026 included allowing resident to express his thoughts and feelings and find positive outcomes. A Psychiatric progress note dated July 9, 2026, revealed that two days prior to the visit, Resident #1 was involved in a verbal altercation with another resident, admitting he called Resident #1 a 'bitch' when frustrated. A facility report, undated, revealed that on July 5, 2026 at approximately 12:00 p.m. Resident #1 and Resident #2 were eating lunch in the main dining room with Resident #6 at the same table. The report documented that Resident #2 started calling Resident #1 derogatory names. Resident #2 did not stop calling Resident #1 names even though Resident #1 had (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 035276	Facility ID: 035276 If continuation sheet Page 1 of 2

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked him to stop calling him names. Resident #1 then approached Resident #2 when Resident #2 said another derogatory name and Resident #1 raised his hand up and made a motion to brush him on the shoulder and chest. The facility report concluded that no contact was made by Resident #1 to Resident #2 but did not make a conclusion regarding the verbal abuse allegations. In an interview conducted on July 21, 2026, at 12:02 p.m. with Resident #2 who stated that he called Resident #1 a bitch. Resident #2 was observed to become frustrated and asked the surveyor to leave. In an interview conducted on July 21, 2026, at 12:59 p.m. with a Dietary Aide (Staff #19) who reported that on July 5, 2026 he was working the dining room when he came out into the dining room Resident #2 was trying to get his attention. Staff #19 heard Resident #1 say 'come on say it louder to my face'. The Staff #19 stated that Resident #2 said 'Shut up bitch' really loud to Resident #1. The Staff #19 stated that Resident #1 came over and flung his arm at Resident #2's chest to back off Resident #1. The dietary aid stated that is when staff came in and separated the residents. Staff #19 stated at no time Resident #1 and Resident #2 were joking around and that they were angry with each other. Staff #19 stated that he thought this was verbal abuse by Resident #2 because he was not joking and calling Resident #1 derogatory names for no reason. In an interview conducted on July 21, 2026, at 1:26 p.m. with Resident #6 who stated that Resident #2 crossed a line and should have never called Resident #1 a bitch. Resident #6 stated he was seated with Resident #1 and Resident #2 when Resident #2 started calling Resident #1 a 'bitch' loudly in the dining room. Resident #6 stated he was shocked and angry that Resident #2 did this. Resident #6 stated that Resident #1 got very angry and told Resident #2 not to call him that. Resident #6 stated that Resident #2 began yelling other expletives, that he could not remember, at Resident #1 causing Resident #1 to go over to Resident #2. Resident #6 stated that Resident #1 held his position at Resident #2 with his fist wanting to hit him but then ended up pushing him back in the chest. Resident #6 stated it took a while before staff came in and separated the two residents. An interview was conducted with Director of Nursing (DON/Staff #67) on July 21, 2026 at 3:07 p.m. who stated that abuse can be physical, verbal, emotional, or financial. Staff #67 stated that examples of verbal abuse include derogatory statements made to other residents and racial slurs. Staff #67 stated that she was notified after the incident happened with Resident #1 and Resident #2 and it was alleged Resident #1 hit Resident #2. Staff #67 stated that through her investigation she found the two residents had grown up together and would sometimes joke around but Resident #1 had told her he did not hit Resident #2. Staff #67 stated that it was confirmed in her investigation that Resident #2 had a history of being impulsive and utilizing aggressive language which he did during the incident. A review of facility documentation revealed a policy and procedure titled Resident Abuse, Neglect, Misappropriation Policy reviewed & updated on April 16, 2026. The policy and procedure stated, that the facility will not condone abuse by anyone including other residents. The policy goes on to define verbal abuse as any use of oral, written or gestured language that includes disparaging and derogatory term to residents or their families, or within hearing distance, to describe resident, regardless of their age, ability to comprehend or disability.		