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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47910

Based on observations, clinical record review, resident and staff interviews and review of facility policy and procedure, the facility failed to ensure the right to personal privacy was respected and valued for two sampled residents (#6 and #79). The deficient practice could result in resident rights to privacy not honored.

Findings include:

-Resident (#6) was admitted to the facility February 1, 2024 with diagnoses of unspecified injury of the head, abnormalities of gait and mobility, generalized muscle weakness and need for assistance with personal care.

The annual MDS (minimum data set) assessment dated [DATE] included a BIMS (brief interview for mental status) score of 15 indicating the resident had intact cognition.

An initial interview was conducted with resident #6 on March 4, 2023 at 9:28 a.m. Resident #6 stated that staff were either not knocking when they enter the room or was knocking once and not waiting for a reply before entering. Resident #6 stated she had been embarrassed by staff not knocking or waiting for a response before entering, due to being undressed.

An observation was conducted on March 5, 2024 at 2:20 p.m. Resident #6 turned on her call light for assistance. It should be noted that resident's door was closed. At 2:26 p.m., a certified nurse assistant (CNA/staff #9) entered the resident's room without knocking at the door prior to entry. The CNA did not wait for the resident's response and permission to enter; and, did not introduce herself.

An interview was conducted on March 5, 2024 at 2:26 p.m. with the CNA (staff #9) who stated that the correct process when entering a resident's room was to knock and wait for the resident to ask them to enter. The CNA further stated she did not knock on the door prior to her entry to the resident's room; and she did not introduce herself to the resident.

-Resident #79 was admitted on [DATE] with diagnoses of cardiorespiratory conditions, coronary artery disease and heart failure.

(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

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 03/07/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual MDS assessment dated [DATE] included a BIMS score of 15 indicating the resident had intact cognition. An interview was conducted on March 5, 2024 at 2:28 p.m. with resident #79 who stated that staff just come into her room without knocking or waiting for her to tell them to come in. Resident #79 turned on her call light and at 2:34 p.m., a CNA (staff #45) knocked on the resident's door once and proceeded to enter without waiting for the resident's response and permission to enter the room. In an interview conducted with the CNA (staff #45) on March 5, 2024 at approximately 2:37 p.m., the CNA stated that when entering a resident room staff was to knock first, wait for a response before entering and introduce themselves. She stated that with non-verbal residents she will enter the room; however, she stated that resident #79 was verbal. The CNA further stated that she entered the resident's room without waiting for the resident's response that it was okay to go in the room. An interview was conducted on March 5, 2024 with assistant Director of Nursing (ADON/staff #72) who stated her expectation when staff enters a resident's room was for staff to knock, wait for the resident to respond or motion them to enter and to introduce themselves before initiating care. Review of the facility policy on Residents Rights included employees shall treat all residents with kindness, respect and dignity and has the right to personal privacy and confidentiality of his or her personal and medical records, personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.

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 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50026 Based on observations, staff interviews, and facility policy and procedure reviews, the facility failed to meet professional standards of quality care by failing to ensure resident information and a list of resident names to unauthorized personnel were not exposed when the electronic record screen was unlocked and unattended. This failure to meet these professional standards can result in the potential for resident personal information available to be seen by unauthorized individuals. Findings include: During an observation of the medication cart conducted on March 6, 2024 at 7:50 a.m., there was an uncapped syringe and pill cup filled with an assortment of pills that were left unattended on a cart. The electronic health record (EHR) was open and uncovered, displaying a resident's picture and list of medications. The registered nurse (RN/staff #161) who was responsible for the medication cart and the EHR was found in alcove with another patient; and the pill cup, syringe, and EHR screen were out of the line of sight of the nurse. In another medication administration with the RN (staff #161) conducted, The RN walked away from the medication cart with an unlocked EHR that revealed a view to a list of residents' names. The RN was about to enter a resident's room for medication administration before she was stopped to lock the screen to the EHR. During an interview with the Assistant Director of Nursing (ADON/staff #72) on March 7, 2024, at 2:06 p.m., the ADON stated that nurses were expected to lock the medication carts and the facility's EHR when stepping away from the screen and medication cart. She also stated that this could lead to a resident grabbing medication or having access to personal health information. The facility policy on Resident Rights reviewed January 5, 2023 revealed that the unauthorized release, access or disclosure of resident information is prohibited. All release, access or disclosure f resident information must be in accordance with current laws governing privacy of information issues. Review of the facility policy Medication Administration reviewed in October of 2023 revealed that no medications will be left unattended at the bedside for any reason and that nurses must ensure that the medication cart is securely locked at all times when not in the nurse's view.

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 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. 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. (continued on next page)

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 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	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)

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 03/07/2024
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	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)

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 03/07/2024
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	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)

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 03/07/2024
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	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.

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 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 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** 46606 Based on clinical record review, staff interviews and policy review, the facility failed to ensure that care plan was updated and revised as needed for one resident (#15). The deficient practice could result in resident not receiving appropriate treatment/services to meet their needs. Findings include: Resident #15 was admitted on [DATE] with diagnoses of anxiety disorder, major depressive disorder, and multiple sclerosis. Review of the quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 15 indicating that the resident was cognitively intact. The MDS also included that the time of the assessment 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 was not updated to address the resident's behavior and did not include interventions to address resident's behavior to intimidate roommates or tendency to use wheelchair to bump into people. An interview with a Licensed Practical Nurse (LPN/staff #123) was conducted on March 7, 2024 at 1:09 p.m. The LPN said that care plan was supposed to be updated following a resident to resident altercation to mitigate further incidents. During an interview with the Assistant Director of Nursing (ADON/staff #58) conducted on March 7, 2024 at 1:38 p.m., The ADON stated that it is the expectation that the care plan is updated following a resident to resident altercation, an incident or new behavior in order to meet the resident's needs. During the interview a review of the clinical record for resident #15 was conducted with the ADON who stated that there was no care plan update or revision following the incident between residents #63 and #15. The ADON further stated that there should have been an update in interventions to assist the resident with behavior; and that, not updating the care plan could lead to resident to resident incident happening again. Furthermore, she noted that updating the care plan helps staff know what is going on with the resident in order to meet their needs. (continued on next page)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Care Plans, Comprehensive Person-Centered dated October 2023 stated that assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. When possible, interventions address the underlying sources of the problem areas, not just the symptoms or triggers. Review of facility policy titled Abuse and Neglect dated January 9, 2024 stated that it is the responsibility of the facility 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 interventions on a regular basis.

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 03/07/2024
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on observation, resident and staff interviews, clinical record review and facility policy and procedures, the facility failed to ensure care and services related to an indwelling urinary catheter was provided to one resident (#47). The census was 96. The deficient practice could result in residents being at risk for urinary catheter complications and urinary tract infections. Findings include: Resident #47 was admitted on [DATE] with diagnosis of urinary tract infection (UTI), sepsis, unspecified organism and type 2 diabetes mellitus (DM) without complications. The care plan dated January 25, 2024 revealed the resident had altered elimination as exhibited by bowel incontinence and indwelling Foley catheter. The goal was that the resident will not develop a urinary tract infection related to Foley catheter use. Interventions included barrier cream incontinent care to prevent skin breakdown; catheter care per facility policy; assistance to the commode/toilet with morning care, before and after meals, with bedtime care, and as needed; assistance with urination/bowel movements; and, performing a thorough peri-care after each incontinent episode. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. The MDS assessment also revealed the resident had an indwelling urinary catheter, was dependent for toileting hygiene and required partial to moderate assistance for transfers. The physician order dated February 22, 2024 revealed the following orders: -Indwelling catheter to straight drainage, 16 fr 10 cc (cubic centimeter) for diagnosis of retention; -Catheter Care Q shift and prn; -Change catheter bag every night shift every Sunday for infection control; and -Change Foley Catheter monthly and prn for blockage or obstruction, every night shift every 4 weeks on Thursday for catheter Care. In an observation conducted on March 6, 2024 at approximately 8:54 a.m., resident #47 was observed being wheeled by a staff through the facility hallway with her catheter tubing exposed on her right leg, the catheter bag with urine was uncovered and was attached to the bottom cross bars of the resident's wheelchair. The uncovered catheter bag was dragging on the floor as the resident was being pushed in her wheelchair. (continued on next page)

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 03/07/2024
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 6, 2024 at 8:59 a.m. with a Licensed Practical Nurse (LPN/Staff #163) who was observed pushing the resident in the hallway. The LPN was asked to observe the placement of the resident's catheter tubing and catheter bag. The LPN stated it was incorrect placement and should not touch the floor and should have a cover on the bag. She further stated the risks associated with the catheter bag dragging on the floor put the resident at risk for contamination and urinary tract infection (UTI). The LPN then proceeded to place the catheter bag correctly and covered the catheter tubing on the resident's lap. In an interview with resident #47 conducted on March 6, 2024 at 12:34 p.m., the resident stated that urinary catheter care was provided by staff once a day or when it itches. Resident #47 stated the catheter was placed when she was admitted to the hospital, but she does not recall why it was inserted. Resident #47 also said that she had a urinary tract infection and was receiving antibiotics for it. An observation conducted during the interview revealed that the resident's catheter bag was uncovered and was touching the floor while the resident was lying in bed. An interview was conducted on March 6, 2024 at 12:36 p.m. with a certified nursing assistant (CNA/staff #165) who stated that when providing peri care and if the resident was a female, staff will clean the tubing with wet wipes and wipe away from the vaginal area. She stated catheter care was provided every brief changes and care provided was documented in the resident's electronic record. The CNA further stated that the catheter bag was drained every shift and she will report any concerns or changes to the nurse. During the interview, an observation of resident #47 was conducted with the CNA who stated that the resident's catheter bag should not be touching the floor and should be placed below the resident's waist. The CNA said that the risks associated with the bag touching the floor and improper placement of the tubing could result in bacteria and germs that cause UTI. The CNA then proceeded to reposition the resident's indwelling catheter tubing and raised the resident's bed to prevent indwelling catheter tubing/bag from touching the floor. An interview with registered nurse (RN/staff #161) was conducted on March 6, 2024 at 12:52 p.m. The RN stated that depending on the type of indwelling catheter, the CNAs were trained to provide catheter care and in-service training were done regularly with staff. She stated preventative interventions had been implemented to minimize complications from urinary catheter for the resident with standing orders to change the bag, assess the flow and integrity of the urine and ensure the resident did not have discomfort or pain. The RN further stated that the correct placement of the indwelling catheter bag was below the patient for easy flow; there should be no bends in the catheter tubing; and, the catheter tubing should not be touching the floor. The RN said the risks associated with incorrect placement of indwelling catheter bag/tubing were contamination and increased chance of the resident getting an infection. During an interview conducted with Assistant Director of Nursing (ADON/staff #72) conducted on March 6, 2024 at 1:11 p.m., the ADON stated that indwelling urinary catheter care can be done by either the nurse or CNA. The DON said that the indwelling catheter should be cleaned with each incontinent episode; the catheter bag should be hanging off the floor but draining to gravity; and, a cover should be placed over the bag so urine shall not be visible. She stated indwelling catheter bags were changed every seven days and indwelling catheter tubing every 30 days; and, these tasks were documented in the Treatment Administration Record (TAR) when completed. The ADON said that in-service training on catheter care, maintenance and cleaning, how often bags and catheter are changed were provided to staff by the infection control preventionist. The ADON further stated that the facility had placed an order for catheter bag covers for any residents with indwelling Foley catheter. (continued on next page)

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy on Urinary Catheters and Incontinence reviewed and revised on January 4, 2024 included that the facility strives to ensure that very resident receives the necessary care and services that will maintain the highest practicable physical, mental, and psychosocial well-being, to assist with meeting this. The facility will provide all necessary treatment and services to prevent urinary tract infections and help restore as much normal bladder function as possible. The facility policy on Urinary Catheter Care reviewed on January 2, 2024 included to be sure the catheter tubing and drainage bag are kept off the floor.

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 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50026 Based on observations, staff interviews and review of the facility policies/procedures, the facility failed failed to keep two of the four medication carts locked and under the direct supervision of authorized staff; and, failed to ensure that medications were not left unattended on the medication cart. The facility also failed to keep two of the four medication carts locked and under the direct supervision of authorized staff in an area where residents could access them. Findings include: During an observation of the medication cart conducted on March 6, 2024 at 7:50 a.m., there was an uncapped syringe and pill cup filled with an assortment of pills that were left unattended on a cart. During an observation of the medication storage areas with a Licensed Practice Nurse (LPN/staff #161) conducted on March 6, 2024, at 1:50 p.m., two unlocked and unsupervised medication carts were in an unlit alcove of Hall B of the facility. These carts had over-the-counter medications easily accessible in the top drawer of both carts. In an interview with the LPN (staff #161) immediately following the observation, the LPN stated that a resident could take and ingest medications that were not theirs to take. During an interview with the Assistant Director of Nursing (ADON/staff #72) on March 7, 2024, at 2:06 p.m., the ADON stated that nurses were expected to lock the medication carts and the facility's EHR when stepping away from the screen and medication cart. She also stated that this could lead to a resident grabbing medication or having access to personal health information. Review of the facility policy Medication Administration reviewed in October of 2023 revealed that nurses must ensure that the medication cart is securely locked at all times when not in the nurse's view.

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 03/07/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50026 Based on observation, staff interviews, and review of facility policy and procedure, the facility failed to implement infection control practices for resident care when preparing insulin for medication administration; and, failed to clean single-resident insulin pens prior to administration. The deficient practice could result in resident to developing infection and complication. Findings include: During a medication administration observation with license practical nurse (LPN/staff #123) conducted on March 6, 2024 at 10:44 a.m., the LPN was preparing insulin medication for one resident and the LPN did not wipe the single-resident use needle insertion site with an alcohol swab on before placing the needle for administration. In an interview with the assistant of director of nursing (ADON/staff # 72) conducted on March 7, 2024 at 2:06 p.m., the ADON stated that nurses were expected to follow the 5 rights of medication administration, lock their computer screens and medication carts when stepping away. The ADON stated that it was expected for nurses to check blood sugars and insulin orders prior to insulin administration; and that, for nurses to clean the top of the container of insulin and the skin injection area with an alcohol swab prior to administering the insulin. Further, the ADON stated that the possible impact of not cleaning the top of the container of the site of injection prior to administration would be a risk for infection and cellulitis. Review of the facility policy on Medication Administration revealed that nursing staff will administer injections using the current standard of practice and following guidelines; and, proper administration technique will be used (e.g., maintenance of sterility, correct needle size, correct).