

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026
NAME OF PROVIDER OR SUPPLIER Oasis Nursing & Rehab of Green Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Delmar Gardens Drive Henderson, NV 89074	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure an allegation of abuse was reported to the State Agency within the required timeframe for 1 of 3 sampled residents (Resident 1). The deficient practice had the potential to delay reporting of alleged abuse and place the resident at risk for continued abuse. Findings include: Resident 1 (R1) was admitted [DATE], with diagnosis including osteomyelitis, cognitive communication deficit, and dementia unspecified severity without behavioral disturbance, psychotic mood disturbance, mood disturbance and anxiety. On 04/13/2026 at 8:55 AM, R1 reported that a Certified Nursing Assistant (CNA) became upset because they played with the sheets and did not pay attention to the CNA. R1 indicated the CNA was rude and hit them in the right eye, on purpose, not by accident. R1 explained their eye hurt that day and no one checked R1's eye. R1 reported the incident to the nurse that same day and did not get a response from them. R1 explained they did not feel safe at the facility because what happened could happen again. A facility Abuse/Neglect/Exploitation/Sexual-In-Nature/Theft Questionnaire dated 04/04/2026, documented R1 reported to a Registered Nurse (RN), when they were being changed a CNA was moving R1 around and R1 did not like it. R1 raised their hands and when the CNA turned around R1 pushed the CNA. The CNA hit R1 in the eye. The RN called the Acting Director of Nursing to report the incident. R1 had a red mark below the eye and redness to the eye. A Skin assessment dated [DATE] completed by a Registered Nurse documented an abnormal finding including a red mark under the right eye and redness to his right eye. A Resident Investigation Form (Staff-Statement) dated 04/07/2026, with an attached written statement, signed by a Licensed Practical Nurse (LPN), documented R1 reported they did not want anything to do with the CNA because the CNA had hit them in the face in the morning and held their hands down and punched them in the right eye. Physician Notes dated 04/07/2026, documented the physician was called for redness around the right eye. R1 was hit but could not recall the incident. A handwritten statement dated 04/07/2026, signed by a CNA, documented R1 reported their eye was hurting and R1 was assaulted. R1 reported a CNA held hands and hit them in the face. The medical record documented R1 reported the alleged abuse to multiple staff members. The facility lacked documented evidence the allegation of abuse was reported to the State Agency. The medical record lacked documented evidence the allegation of abuse had been reported to the Administrator until 04/07/2026. A Summary of Investigation and Findings dated 04/09/2026, signed by the Administrator, documented based on a thorough investigation, the abuse allegation was not substantiated. On 04/13/2026 at 10:08 AM, the Administrator explained the abuse allegation received from R1 on 04/04/2026 was reported to them on 04/07/2026. The Administrator reported if an allegation of abuse was identified over the weekend, the Administrator would be contacted by staff for the purpose of reporting allegations of abuse. The Administrator explained they usually would have reported the abuse allegation to the State Agency and then investigated. The Administrator decided to investigate first and based on the conclusion of the investigation which included R1's known behavior, difficulty with staff of certain races and history of making allegations and made the decision not to report the allegation of abuse to the State Agency. The Administrator (continued on next page)</p>

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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>acknowledged facility's policy documented all allegations of resident abuse were to be reported to local, state and federal agencies, however explained this particular allegation of abuse was not reportable because the allegation of abuse was unsubstantiated. On 04/13/2026 at 11:01 AM, the Acting Director of Nursing, acknowledged facility's policy documented that all reports of resident abuse were reported to local, state and federal agencies as required and thoroughly investigated by facility management. The Acting Director of Nursing stated the Administrator upon receiving allegations of abuse, was responsible for determining what actions, if any, were needed for the protection of the residents. The Acting Director of Nursing acknowledged the Registered Nurse who received the allegation of abuse on 04/04/2026 did not notify the Administrator as required. Allegations of abuse were to be reported within 2 hours to 24 hours. On 04/13/2026 at 1:10 PM, a Registered Nurse (RN) explained in the event of an altercation between residents the RN immediately separated the residents, assessed residents to determine if injury or medical attention was needed. The RN reported abuse to the supervisor, the Director of nursing, physician and police. The RN explained abuse had to be reported immediately. The Director of Social Services indicated the facility had reported incidents, including abuse allegations, to the State Agency. The Director of Social Services explained R1 had a history of making stories and false allegations. The Director of Social Services reported receiving guidance about 10 years ago indicating that when a resident's history of false allegations was documented in the care plan, abuse allegations did not need to be reported to the State Agency and could instead be handled internally as a soft file investigation. If an allegation could be resolved internally, it was not considered reportable. When asked about the facility's policy on reporting abuse and required timelines, the Director of Social Services was unable to identify any policy requiring all abuse allegations to be reported to the State Agency. A Facility Reporting and Investigation Checklist documented, Protect the Resident! You must call 911 immediately (not later than 2 hours after the allegation was made) if you witness or suspect a crime or if the events that caused the allegation are sexual in nature (inappropriate touching i.e.) or involved abuse, neglect or results in serious bodily injury. Contact the Administrator, Director of Nurses, or Director of Social Services immediately. A facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022, documented all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property were reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations were documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source was suspected, the suspicion must have been reported immediately to the Administrator and to other officials according to state law. Immediately was defined as within two hours of an allegation involving abuse or resulting in serious bodily injury or within 24 hours of an allegation that did not involve abuse or result in serious bodily injury. Complaint 2978946</p>		