

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/17/2026
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)		
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure 1 of 50 residents (Resident 205) with a Full Code status was provided basic life support (BLS) after being found unresponsive. Facility staff did not initiate cardiopulmonary resuscitation (CPR) as required. This deficient practice deprived the R205 of required life-saving measures, specifically CPR, which may have potentially increased the resident's chance of recovery and survival. Findings include: Resident 205 (R205) admitted on [DATE] with diagnoses including acute respiratory failure. A nursing progress note dated [DATE], documented at approximately 8:15 AM when the Registered Nurse (RN) was doing rounds the patient was found unresponsive to verbal and tactile stimuli, no heartbeat noted, no pulse, no respirations, pupils were fixed and fully dilated. The RN called and made the house supervisor aware of the incident. A Physician order dated [DATE] documented an order of Full Code status for R205. A review of R205's Nevada Provider Order for Life-Sustaining Treatment (NV POLST) dated [DATE] revealed a checkmark in the designated box Attempt Resuscitation (CPR -cardiopulmonary resuscitation) under section A. This section applied when the patient had no pulse and was not breathing. The form documented when not in cardiopulmonary arrest to follow orders in Section B and C. Section B documented the Full Treatment which indicated to prolong life by all medically effective means. R205's Code status form dated [DATE] documented to administer cardiopulmonary resuscitation (CPR). The medical record showed the last documented blood pressure was recorded on [DATE] at 4:37 PM, with a reading of 100/76, taken manually by the Registered Nurse, (RN). The medical record lacked documented evidence the following actions were performed upon discovery of R205 as unresponsive: Vital signs were taken. CPR was initiated or administered. Change in condition protocols were completed. A comprehensive nursing assessment was conducted. Emergency Medical Services (EMS) were contacted. The physician instructed the RN supervisor to discontinue CPR efforts or cancel paramedic response. An official pronouncement of death was determined. On [DATE] at 3:55 PM, the Clinical Resource Nurse and Interim Director of Nursing (DON) confirmed that no automated external defibrillator (AED) summary report sheet had been completed for resident R205 on [DATE]. The Clinical Resource Nurse verbalized the expectation for the RN was to complete thorough documentation, including vital signs, the resident's condition, and criteria indicating whether R205 met or did not meet requirements for interventions. Documentation should have reflected whether CPR was initiated, as well as the time and details of the physician notification. The Clinical Resource Nurse reported while RNs were permitted to pronounce death under the facility's standing order, an order to pronounce must be obtained from the physician. On [DATE] at 2:48 PM, a Licensed Practical Nurse 3, (LPN3), confirmed when a resident was unresponsive an assessment would be conducted and CPR would begin because delaying CPR could cause further life changing effects. The LPN (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
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	clarified basic life support (BLS) certification directed staff not to delay the first compression when an individual was found unresponsive and represented the residents' life changing choices. The LPN indicated the automated external defibrillator (AED) should be present. On [DATE] at 2:54 PM, Registered Nurse 4 (RN4), CPR must be conducted when a resident was full-code status and denying or not performing CPR on a resident is against a resident's choices and BLS certification standards. The RN acknowledged the AED should have been nearby for use if needed. On [DATE] at 2:58 PM, RN5, indicated when a resident was discovered unresponsive the nurse would conduct an assessment and start CPR for a full-code resident. The RN indicated AED was present in case it needed to be utilized. RN5 BLS standards were not to delay the first compression when an individual was found unresponsive. On [DATE] at 3:05 PM, LPN1, verbalized once a resident was found unresponsive an assessment would be conducted, call for help and start CPR for a full-code resident and AED should be present. The LPN confirmed BLS standards were not to delay the first compressions. On [DATE] at 5:18 PM, LPN4 reported being asked by RN1, to assist because it appeared R205 had passed. Upon arrival, LPN4 agreed with RN1's assessment that R205 was deceased and CPR was not initiated, instead the house supervisor was contacted. LPN4 verbalized their observations were the reason CPR was not initiated. The LPN acknowledged CPR may not have been performed because the resident appeared deceased. The LPN did not obtain vital signs and could not recall whether the assigned RN obtained vital signs. The LPN clarified it was not within the LPN's scope of practice to determine death or decide not to initiate CPR. On [DATE] at 5:24 PM, LPN4 confirmed the assigned RN did not initiate CPR but instead contacted the LPN for assistance. The LPN indicated they were unfamiliar with the facility's AED and did not recall anyone bringing it to the scene. The LPN indicated the backboard was not placed, the crash cart was not brought to the room, and an AED was not present. The LPN confirmed BLS certification directed staff not to delay the first compression when an individual was found unresponsive, but the LPN deferred the decision to the two RNs present. On [DATE] at 7:23 AM, a phone interview was conducted with a physician regarding the incident when R205 was found unresponsive. The physician reported receiving a call from the RN supervisor at approximately 8:15 PM concerning R205's condition. According to the physician, the RN supervisor indicated R205's vital signs had been assessed a few hours prior and were within normal limits, with no concerns noted throughout the shift. The RN supervisor reported that when the assigned RN discovered R205, the resident's eyes were fixed, there were no respirations or heartbeat, and rigor was present. The physician indicated that the RN supervisor reported CPR was not initiated because R205's physical presentation indicated that resuscitation would not be feasible. The physician clarified during the call R205 was designated as full-code and CPR should have been initiated if any signs suggested the possibility of resuscitation. The physician verbalized the RN supervisor reported CPR would not be conducted due to the observations of R205s current condition, therefore, 911 was not contacted. On [DATE] at 8:10 AM, the Clinical Resource Nurse and Interim DON confirmed there was no AED summary report pertaining to R205s code in the medical record. Additional review of R205s medical record lacked documented evidence of the following: The death record dated [DATE] at 8:15 PM, had no check mark by the pronouncement of death for R205. R205 was pronounced deceased or expired prior to contacting the cremation service provider for pick up. On [DATE] at 12:42 PM, the Minimum Data Set (MDS) coordinator confirmed the facility has not conducted any mock code drills during their 17 years of employment. The MDS coordinator indicated mock code drills would be beneficial in improving staff competency in responding to code situations, especially because code events did not occur often within the facility. On [DATE] at 12:43 PM, the Infection Preventionist (IP), reported not having participated in any mock code drills during the two years of their employment. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to use the correct technique when applying a mechanical lift sling for 1 of 50 residents (Resident 102) who requires care in pairs. This deficient practice constituted past non-compliance, existing from 05/22/2026 to 05/26/2026. The facility returned to compliance on 05/26/2026 prior to the start of the current survey, after implementing corrective actions including staff termination, disciplinary actions, removal of incorrect sling sizes, and 100% staff competency retraining. This deficient practice had the potential to increase serious body harm and risk of injury to the resident. Findings include: Resident 102, (R102) was readmitted on [DATE] with diagnoses including fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing. On 07/16/2026 at 8:39 AM, an observation of R102's room revealed the mechanical lift sling was not present. On 07/16/2026 at 9:05 AM, an inspection of the 100-unit linen closet revealed a box containing various individually bagged slings. Each bag contained a sling of a different color. A Certified Nursing Assistant (CNA) identified as CNA3 indicated all pink slings had been removed from the unit entirely. An Alert Note dated 05/22/2026 documented that staff were called to room [ROOM NUMBER]B where the resident was found lying face down on the floor. The RN Supervisor was notified, and 911 was contacted for transport to the emergency room. Staff did not reposition the resident and waited for paramedics to arrive. The resident was documented as alert and oriented to person and place (AOx2) and complained of pain to the neck and forehead. Paramedics arrived and transported the resident to the emergency room. The resident's emergency contact was notified, and the physician was informed of the fall. A nursing note dated 05/22/2026 documented staff were called to the resident's room where the resident was found to have sustained a fall. The resident was awake and lying on his left side in a prone position on the carpet, with no signs or symptoms of respiratory distress observed. Emergency services (911) were called STAT. At 11:20 AM, paramedics transported the resident to the emergency room via stretcher. At 12:00 PM, the primary care provider was notified of the incident. A nursing note dated 05/25/2026 documented the resident was readmitted to the facility with a femoral neck fracture, a bunny boot applied to the left foot, +2 pitting edema to the left foot, a right scalp abrasion, and blanchable redness to the bilateral heels and buttocks. A hospital Discharge summary dated [DATE] documented R102 presented to the hospital after experiencing a fall with head impact during a transfer from bed to wheelchair using a mechanical lift. Hospital imaging (X-ray) showed an acute, mildly impacted left femoral neck fracture. The discharge summary indicated that, based on these findings, there were concerns for a left femoral neck fracture requiring surgical intervention. The care plan dated 04/17/2026 documented R102 required Cares in Pairs for all ADL assistance. The care plan goal documented R102 needs would be met and cares would be provided safely. Documented interventions included direct care staff to pair two staff members together when providing cares and to place a Cares in Pairs sign above the resident's door to ensure staff are alerted to this requirement. On 07/16/2026 at 8:00 AM, three Certified Nursing Assistants (CNAs), identified as CNA5, CNA6, and CNA7, were observed transferring a resident from a shower bed to a standard bed. The transfer was performed using a three-person assist. One CNA was positioned at the back of the resident utilizing the pull handle, while the remaining two CNAs were positioned on each side of the resident. The lift contained four hooks, two supporting the upper body and two supporting the lower body. The resident was lifted from the shower bed and lowered onto the bed without noted issues. On (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	07/16/2026 at 8:34 AM, R102 was interviewed regarding the 05/22/206 fall incident. R102 recalled that on the day of the incident, CNA4 entered the room to assist R102 out of bed for a scheduled appointment using a mechanical lift, CNA4 was alone and not accompanied by a second CNA. R102 verbalized that the care required two CNAs to assist. R102 indicated CNA3 later entered the room to assist with the transfer. R102 verbalized that once lifted and no longer positioned over the bed, the mechanical lift began to move unexpectedly. R102 indicated CNA4 attempted to stop the movement, at which point R102 fell forward out of the sling, landing headfirst. R102 reported the sling remained attached to the mechanical lift during the fall. On 07/16/2026 at 8:41 AM, CNA5 reported awareness of R102's fall that occurred approximately one and a half months prior during a mechanical lift transfer. CNA5, CNA6, and CNA7 were not on duty at the time of the incident; however, the CNAs became aware of the details through in-service training provided afterward. CNA6 explained the facility had multiple sling sizes available for use for the mechanical lift however, CNA6 indicated the staff were uncertain whether the correct sling size had been utilized for R102 at the time of the fall. On 07/16/2026 at 8:50 AM, the Infection Preventionist (IP) indicated the facility's policy indicates that two CNAs must be present to do a transfer of a resident with a mechanical lift. On 07/16/2026 at 9:00 AM, CNA3 indicated upon entering the room to assist CNA4 with a mechanical lift transfer, CNA3 identified CNA4 had already placed the sling underneath R102. CNA3 reported R102 was designated as a care in pairs resident and CNA4 should have had an additional CNA present prior to initiating care. CNA3 clarified their role was to guide the mechanical lift while CNA4 was responsible for guiding R102 into the wheelchair. CNA3 verbalized that once R102 was positioned in the mechanical lift, R102 jerked, causing R102 to fall out of the sling. CNA3 acknowledged that at the time of the incident involving R102's fall, it was identified that the incorrect sling had been attached to the mechanical lift and the sling used was too small for R102. CNA3 confirmed that following the incident, the Director of Nursing (DON) instructed CNA3 and CNA4 to demonstrate and reenact the events of the mechanical lift transfer and both were sent home for the remainder of the day. CNA3 indicated that both CNAs received written disciplinary action and additional training before being placed back on the work schedule. On 07/16/2026 at 9:49 AM, the DON provided the employee record for CNA4, which indicated CNA4 had received a final disciplinary action and was ultimately terminated for various unrelated concerns. The DON also provided information showing CNA3 received a written disciplinary action related to the mechanical lift transfer incident involving Resident R102. CNA3 and CNA4 were provided with additional training and competency testing immediately following the incident before returning to the work schedule. On 07/16/2026 at 8:47 AM, CNA8 indicated that during a mechanical lift transfer, facility policy required two CNAs to be present one to guide the mechanical lift and the other to guide the resident. CNA8 clarified that a sling could not be applied without two CNAs present and that transferring a resident alone is against facility policy. CNA8 indicated the facility conducted training a few months prior regarding proper mechanical lift techniques, sling sizing, and the importance of two-staff mechanical lift transfers. On 07/16/2026 at 9:07 AM, CNA3 indicated mechanical lift transfers required two CNAs at all times due to safety considerations for both the resident and staff. CNA3 reported additional training was conducted following Resident R102's fall during a mechanical lift transfer. The training addressed proper use of various sling sizes, correct mechanical lift transfer techniques, and the importance of having two staff members present during all mechanical lift transfers. CNA3 explained that the facility utilizes multiple sling sizes that are color-coded: pink for extra small, purple for small, green for medium, and blue for large. CNA3 indicated the slings were stored in linen closets, and CNAs were responsible for selecting the appropriate sling size for each resident during transfers. On 07/16/2026 at 9:28 AM, CNA9 indicated (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	mechanical lift transfers required two CNAs at all times. CNA9 clarified that one CNA was responsible for guiding the mechanical lift, while the other CNA guided the residents to ensure safety. CNA9 reported the facility conducted training for all CNAs and nurses on mechanical lift protocols and procedures following Resident R102's fall incident. CNA9 indicated the facility provided various sling sizes for resident transfers and CNAs were required to select the correct sling size before applying it to ensure resident safety and prevent falls. CNA9 explained monthly meetings were held covering various facility topics, with mechanical lift transfers being a primary focus. CNA9 indicated the DON routinely checked mechanical lift practices to ensure staff compliance with proper protocols. On 07/16/2026 at 9:48 AM, the DON provided mechanical lift training records dated May 22, 2026. The records indicated that weekly huddles were conducted on various topics, with falls and mechanical lift procedures identified as priority areas. The DON verbalized a CNA had recently been suspended for attempting to transfer a resident alone. The DON clarified that licensed nurses were responsible for ensuring CNAs performed mechanical lift transfers with two staff members present; failure to follow this protocol must be reported, resulting in a final write-up and suspension for the CNA involved. The DON indicated the facility conducted a quarterly CNA skills fair, which included Nevada scope competency testing and skills assessments for CNAs. On 07/16/2026 at 10:18 AM, LPN7 indicated mechanical lift transfers required two staff members at all times. LPN7 reported the facility provided various sling sizes to ensure proper and safe transfers. LPN7 clarified using an incorrect sling size may result in a resident slipping out of the sling, causing serious injury, which was why two CNAs are required to verify the correct sling size prior to application. LPN7 indicated that mechanical lift transfer procedures and fall prevention topics are addressed during every staff huddle. LPN7 confirmed CNAs are required to demonstrate weekly competency in mechanical lift transfers as part of ongoing facility safety practices. The facility policy titled Lifting Machine, Using a Mechanical, revised July 2017, indicated that at least two nursing assistants were required to safely move a resident with a mechanical lift. It further directed staff to measure the resident for the proper sling size and to visually verify that the sling was not too large or too small before use. Complaint 3033147		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure an accurate process was implemented for receiving, documenting, and safeguarding resident personal funds for 1 of 50 sampled residents (Resident 56). The deficient practice had the potential to result in inaccurate accounting of resident funds, financial loss, and the inability to verify funds entrusted to the facility. Findings include: Resident 56 (R56) was admitted [DATE], with diagnoses including aphasia following cerebral infarction, unspecified protein calorie malnutrition, and abnormalities of gait and mobility. Document review revealed the facility reported R56 questioned the balance of the resident's trust account and they should have had \$200 in the trust account. The facility's investigation revealed the resident had provided two \$100 dollar bills to the receptionist for deposit into the trust account but received a receipt reflecting only \$100. The Business Office subsequently located the two \$100 bills attached to a receipt which reflected \$100. On 07/14/2026 at 10:35 AM, R56 explained the missing money situation was cleared up by the facility when R56 reported they should have had a \$200 balance. R56 did not want to discuss all details of the incident. On 07/14/2026 at 12:16 PM, the Business Office Manager, explained when residents brought in cash, a two-part receipt should have been written, one part should have gone to the resident, the second part should have been paperclipped with the cash placed in a bag, in sealed envelope so the funds were separated by resident and taken to the business office. On 07/15/2026 at 12:23 PM, the Director of Social Services, reported R56 asked about their account balance/statement. The Business Office found \$200 with a receipt attached that reflected only a \$100 deposit. The Director of Social Services confirmed it was a receipt problem, R56 deposited \$200 but was given a receipt of \$100 in error. The Director of Social Services reported the confusion may have happened because the facility changed from clipping money together to instead placing the money in an envelope. This change may have affected the process. The Director of Social Services confirmed the facility did not provide the residents with an accurate receipt and the funds were found clipped together with an inaccurate receipt. The Director of Social Services did not know how the process should have worked. This surveyor was referred to speak to reception regarding the correct process that should have been followed. On 07/15/2026 at 12:37 PM, a facility receptionist explained when residents turned in funds, a receipt was to be written, the money placed in an envelope and given to Business Office to deposit the funds. The receptionist indicated R56 reported the funds were missing and they were found in the Business Office. The receptionist acknowledged did not know what went wrong with the process of depositing funds for R56. On 07/16/2026 at 8:16 AM, the Assistance Business Office Manager reported the Receptionist should have separated R56's funds correctly in an envelope when received to avoid confusion with R56's funds. The receptionist explained envelopes were implemented again after the incident with R56 and acknowledged it was R56's right to have an accurate account of their funds and access to them. A facility document titled Procedure for Receipt of Payments and Resident Funds, (undated), documented all cash or other forms of payment received for a resident must be verified immediately upon receipt. A pre-numbered three-part receipt must be completed immediately upon receipt of funds. The receipt must include the date, resident name, and amount received. FRI 3018499		