

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2024	
NAME OF PROVIDER OR SUPPLIER OAKMONT OF THE LAKES				STREET ADDRESS, CITY, STATE, ZIP CODE 3250 S. FORT APACHE ROAD, LAS VEGAS, NEVADA ,89117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an Complaint State Licensure survey completed at your facility on 03/14/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 120. The sample size was six. The facility received a grade of A. There was one complaint investigated. Verified without deficiency: Complaint #NV00070439 was verified without deficient practice. Investigation of the complaint included: Observation of medications available for residents and residents who are able to self medicate. Interviews were conducted with residents, the Executive Director, the Health Services Director and Medication Technicians. Record review of six residents, including the resident of concern. Document reviews including policies on Narcotic Counts, Assessments and Service Plans and Incident Reports. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no deficiencies identified. Maintain a copy for your	0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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.