Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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 annual State Licensure and infection control survey conducted at your facility on 04/21/23, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility was licensed for 150 Residential Facility for Group beds for elderly or disabled persons, and/or persons with chronic illness, and/or persons with mental illness, and/or persons with intellectual disabilities, and/or persons with Alzheimer's disease, and/or Assisted Living Services, Category II residents. The census at the time of the survey was 85. Twenty resident records and ten employee records were reviewed. The facility received a grade of C. 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. The following regulatory deficiencies were identified:	0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and record review, the facility failed to ensure a two step tuberculosis (TB) screening was completed upon hire for 2 of 10 employees (Employee #7 and Employee #8). Employee #7 was hired on 01/11/23 and Employee #8 was hired on 01/26/23. Employee #7 completed a TB screening on 12/29/22 and Employee #8 completed a TB screening on 09/20/22. There was no documented evidence of a second step TB screening for Employee #7 and Employee #8. The Business Office Manager confirmed there was no documented evidence of a two step TB test completed for Employee #7 or Employee #8. Severity: 2 Scope: 1	0102	Tuberculosis (TB) screenings were done for employee #7 & #8 prior to surveyors visit. The test/results were located and placed in employees files. An audit will be conducted of all current staff and any missing required TB tests will be completed. We have implemented a TB Clinic monthly for staff and residents to start on 5/19 and an audit tickler to be maintained by Business Office Director and review monthly by ED. Please see attached documents. #7 TB completed date: 1/7/23 #8 TB completed date:1/22/23	04/21/2023
0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on interview and record review, the facility failed to ensure cardiopulmonary resuscitation (CPR) training was completed every two years for 1 of 10 employees (Employee #9). Employee #9 was hired on 11/10/22. Employee #9 last completed CPR training on 01/12/21. A Resident Care Coordinator confirmed Employee #9 had an expired CPR certification and needed to complete the training again. Severity: 2 Scope: 1	0106	Cardiopulmonary Resuscitation (CPR) was completed by employee #9 and a copy of the new card placed on file for employee #9. A file audit will be conducted by Business Office Director (BOD) of current staff CPR and any missing CPR training will be implemented and copies retained in employee files. Please see copy attached.	04/21/2023
0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10	0255	a. All culinary team members were in-serviced and retrained by Executive Chef & ED on the proper	05/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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
	residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 04/19/2023, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the walk-in cooler, raw beef was stored above cooked chicken on a speed rack. b. There was a strong sewer odor present in the dish wash area and in the janitor's closet in the kitchen. 2. Major Violations: a. The cutting board on the steam table was stained with deep abrasions. b. The can opener was soiled with food build-up and metal shavings around the blade. 3. Equipment and Maintenance Violations: a. Rust colored water was leaking onto the floor of the walk-in cooler from the shared wall of the dish machine. b. The interior of the microwave in the kitchen was in disrepair. c. The gasket on the door of the under counter reach-in refrigerator was in disrepair. d. There was dust build-up around the ceiling air vents throughout the kitchen. Severity: 2 Scope: 3		use of the walk-in cooler, handling and storing of raw meats and proper storage of cooked foods using the SNHD foodborne Illness Risk Factors and Food Hazard education booklet. completed 5/10 (See attached) b. After much exploring, the walls behind the dishwasher was opened by a contracted plumbing company. The wall was opened that lead to second floor apartment #240. The technician found a cracked pipe that exposed flushed toilet water and shower water seeping into the walls. The technician immediately removed and replaced all cracked pipes and drywalls that were open behind the dishwasher. Once repairs were complete and walls replaced the smell dissipated slowly. Executive Chef and kitchen staff to monitor daily for any unusual smells. ED & Maintenance Director to monitor and review monthly with Executive chef. (completed 5/3/23) See Pictures attached. 2. Major Violations: a. A new cutting board on steam table was ordered and has been installed. In addition single color coded cutting boards were ordered and is in place of old ones in the kitchen. 5/11/23 see pics attached. b. Can opener was cleaned immediately and staff knows to clean right after each use. Executive Chef to ensure it is kept free of food build-up and shavings on daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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
			cleaning schedule. ED to monitor weekly cleaning schedule & during monthly kitchen walk-through with Executive Chef and kitchen team. 3. Equipment and Maintenance Violations: a. Rust colored water was cleaned up and staff knows to clean any pooled water on kitchen floors in the kitchen. Kitchen staff is aware to monitor kitchen floors. Executive Chef to enforce daily and weekly cleaning schedule and oversee kitchen floor maintenance. ED to conduct monthly walkthrough with Executive Chef to ensure floors are mopped and swept as scheduled daily. We have also contracted City Wide Facility Solutions for a deep clean of our kitchen. kitchen was deep cleaned on 5.11.23 b. A new microwave was ordered and has now replaced the old one. completed 5/10 Executive Chef will conduct & oversee daily and weekly cleaning schedule to include microwave and kitchen equipment. Staff is aware to clean after each use to prevent residue buildup. ED to conduct monthly walkthrough with Executive Chef to ensure Microwave and kitchen equipment is cleaned as scheduled. c. Gasket-N-More came and replace the dis-repaired gasket. (5.10.2023). Executive Chef to ensure gasket is replaced timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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
			We have placed a maintenance reminder to check monthly and repair/replace gaskets if needed. ED to check during monthly walkthrough with Executive Chef monthly. (See attached) d. All air vents were cleaned in the Kitchen. All culinary team members were made aware to monitor dust build-up on kitchen vents and to add to weekly cleaning list. Executive Chef to monitor cleaning schedule and ED to ensure vents are cleaned during monthly walk-through. Please see attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview, record review and document review, the facility failed to ensure tuberculosis (TB) testing was completed per the requirement for 2 of 10 sampled residents (Resident #1 and #19). Findings include: Resident #1 (R1) R1 was admitted on 01/29/22 with diagnoses including Alzheimer's disease. R1's medical record contained a QuantiFERON TB test with a read date of 01/14/22. R1's medical record lacked documented evidence an annual TB test was completed. Resident #19 (R19) R19 was admitted on 01/27/22, with diagnoses including Dementia. R19's medical record lacked documented evidence a two-step TB test was completed per the requirement. On 04/19/23 in the afternoon, the Resident Care Director acknowledged R1 and R19 had not completed TB testing per regulation. Severity: 2 Scope:1	0936	Two step tuberculosis (TB) testing was administered for residents #1 and #19 results placed in residents' medical files. A file audit will be conducted of all current residents file for current TB's and any missing required TB tests will be completed. An audit sheet of required elements will be maintained by Wellness Director and reviewed monthly with ED.	05/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to ensure an Activities of Daily Living (ADL's) Assessment was completed annually for 1 of 20 sampled residents (Resident #16). Findings include: Resident #16 (R16) R16 was admitted on 01/24/19 with diagnoses including major depression and hypertension. R16's medical record revealed the last annual ADL's assessment was completed on 05/07/20. R16's medical record lacked documented evidence an ADL's assessment was completed annually. On 04/19/23 in the afternoon, the Administrator acknowledged R16's medical record lacked an annual ADL's assessment. Severity: 2 Scope: 1	0938	An ADL assessment was made effective on 4/19/2023 for resident #16. Resident medical record was reviewed and updated with new ADL assessment. A file audit will be conducted of current residents assessments and any missing assessments will be completed by Wellness Director and files reviewed monthly with ED.	04/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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
1006 SS= F	Adults with Intellectual Disabilities - NAC 449.2762 Residential facility which offers or provides care for adults with intellectual disabilities or adults with related conditions: Application for endorsement; training for caregivers. (NRS 449.0302) 2. Within 60 days after being employed by a residential facility for adults with intellectual disabilities, a caregiver must receive not less than 4 hours of training related to the care of persons with intellectual disabilities. Inspector Comments: Based on interview and record review, the facility failed to ensure four hours of training for residents with intellectual disabilities, was completed within 60 days of hire, for 8 of 10 employees (Employee #1, #2, #3, #4, #6, #7, #8 and #9). Employee #1 was hired on 11/16/22. Employee #2 was hired on 09/28/22. Employee #3 was hired on 12/21/22. Employee #4 was hired on 09/28/22. Employee #6 was hired on 01/17/22. Employee #7 was hired on 01/11/23. Employee #8 was hired on 01/26/23. Employee #9 was hired on 11/10/22. There was no documented Intellectual Disability training in the records of Employees #1, #2, #3, #4, #6, #7, #8 and #9. The Business Office Manager confirmed Employees #1, #2, #3, #4, #6, #7, #8 and #9 did not complete four hours of Intellectual Disability training within 60 days of hire. Severity: 2 Scope: 3	1006	Intellectual disability training started on 5/4 and completed 5/10 for Employees #1, #2,#3, #4, #5 #6, #7, #8 #9 &#10 We have NOT been utilizing the intellectual disability endorsement and has filed an application to remove it. See application attached. ED to follow up on application status.	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121

(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
0053 SS= D	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on observation and interview, the facility failed to ensure an employee file was onsite and available with all required documents for 1 of 10 employees (Employee #10). Findings include: Employee #10 was hired on 01/23/23. There was no documented evidence Employee #10 completed the following: -16 hours of initial Medication Management Training. -4 hours of Intellectual Disability training within 60 days of hire. -2 hours of Chronic Illness training within 60 days of hire. -Cultural Competency training within 30 days of hire. On 04/19/23 in the morning, the Business Office Manager confirmed there was no documented evidence of an employee file onsite for Employee #10 and had no documentation of Medication Management, Intellectual Disabilities, Chronic Illness or Cultural Competency trainings. Severity: 2 Scope: 1	0053	Employee #10 is no longer employed with Oakmont, LV. We have not been utilizing the Intellectual Disability Endorsement and has filed an application to remove it. See application attached. Will keep the board posted on the status as it becomes available -16 hours of initial Medication Management Training. We were not able to locate employee #10 16 hr initial Medication Management training - (Please see her attached 8 hr MT certificate) -4 hours of Intellectual Disability training within 60 days of hire. Please see attached.5/5/23 -2 hours of Chronic Illness training within 60 days of hire. See attached.5/5/2023 -Cultural Competency training within 30 days of hire. See attached. 5/5/23 see attached current Administrator's initial 16hr & 8hr Medication Management training. Application for change of Administrator sent to Beltca on 5.8.23	05/05/2023