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	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**11/14/2023**

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 a complaint investigation initiated in your facility on 10/23/23 and completed offsite on 11/14/23, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The facility was licensed for 150 Residential Facility for Group beds for elderly or disabled persons and/or Alzheimer's disease and/or assisted living services and/or chronic illness and/or individuals with intellectual disabilities, 120 Category II and 30 Category II (Alzheimer's) residents. The census at the time of the survey was 108. The sample size was five. The facility received a grade of A. There were two complaints investigated. Unverified: 1. Complaint #NV00069361 could not be verified. No regulatory deficiencies could be identified. Verified: 2. Complaint #NV00069580 was verified (See Tag Y0878). The investigation of the Complaints included: Observation of the grooming and physical appearance of residents, medication administration to residents, residents interacting with visitors, call bell response, resident care, breakfast and lunch, and a tour of the facility. Interviews were conducted with residents, two Caregivers, two Medication Technicians, Care Coordinators, a Hospice Certified Nursing Assistant and the Business Office Manager. Clinical Record Review of five records, which included the residents of concern. Document Review included facility policies and procedures, menus, posted menus times, and staff schedules. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiency was identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: SUE MCPHERSON Title: VP Reg Oakmont Mgr G Date: 11/21/2023

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.

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0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on interview and record review, the facility failed to	0878	**Problem Identified: Medication ordered was not available** • Medication carts will be audited to ensure that all ordered medications are on hand. To be completed by 11-22-2023 the Resident Care Coordinator. • Weekly audits of the medication carts for presence of all ordered medications will be implemented starting 11-30-2023 by Resident Care Coordinator and monitored by Health Service Director. • Retraining will be conducted on policy for unavailable medications-completed11-18-23 • Ongoing compliance will be monitored by Health Services Director with the assistance of the Resident Care Coordinator and the participation of the Regional Health Services Director during routine visits. **Problem identified: Documentation on the MAR was not accurate** • Documentation on the MAR and the narcotic countdown sheets will be reviewed weekly in conjunction with the medication cart audit starting 11-30-2023 by Resident Care Coordinator and monitored by Health Service Director. • Retraining will be conducted on documentation on the MAR when medication is not given for any reason. Completed 11-16-23 • Retraining will be conducted on the process for reporting a medication error. Completed 11-21-23 • Ongoing compliance will be	11/21/2023

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	ensure a routine medications were available onsite, and administered in accordance with physician's orders for a resident with pain (Resident #5). Findings include: Resident #5 (R5) was admitted on 06/23/22 with diagnosis of sebaceous cell carcinoma. A physician's order dated 09/22/23 documented Tramadol Hydrochloride, 50 milligram tablet, take one tablet every eight hours at 6:00 AM, 2:00 PM and 10:00 PM for pain. On 10/23/23 in the morning, R5 recalled missing doses of the pain medication Tramadol in late September and early October and had experienced pain during that time. R5 reported R5 pressed the call button to receive the pain medication, however staff did not respond to those calls. On 10/23/23 in the morning, two Caregivers indicated they recalled R5 verbalizing R5 was experiencing pain at the beginning of October and were unaware if R5 received pain medications as scheduled, per the physician's order. On 10/23/23 at 10:20 AM, a hospice certified nursing assistant (CNA) indicated witnessing R5 in pain at the end of September and early October. The hospice CNA reported the facility failed to administer R5 the scheduled pain medication Tramadol during these times but was unaware of the reason, as hospice delivered the medication to the facility. Review of the September 2023 Medication Administration Record (MAR) for R5 revealed Tramadol was not administered on 09/30/23 at 2:00 PM or 10:00 PM, per the physician's order. Review of the October 2023 MAR for R5 revealed Tramadol was not administered 10/01/23 at 6:00 AM, per the physician's order. The MAR also revealed R5 did not receive Tramadol on 10/02/23 at 2:00 PM, per the physician's order. On 10/23/23 at 10:55 AM, a Medication Technician confirmed R5 did not receive Tramadol, per the physician's order on 09/30/23 at 2:00 PM, 10/01/23 at 6:00 AM and 10/02/23 at 2:00 PM because it was not onsite and available at the facility. On 11/14/23 in the afternoon, a Regional		monitored by the Health Service Director with the assistance of the Resident Care Coordinator and participation of the Regional Health Service Director during routine visits.	

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	Operations Specialist confirmed R5 did not receive Tramadol, per the physician's order on 09/30/23 at 10:00 PM because it was not onsite and available at the facility. The Regional Operations Specialist revealed Tramadol was onsite on 10/02/23 and was unsure why the 10/02/23 2:00 PM dose was not given. There was lack of evidence the facility could account for the difference in explanations for the missed doses of Tramadol. Review of the Medication Order Policy revised December 2013, documented, a designated staff member is responsible for all medication refills and must ensure the medication is refilled prior to the resident having a seven-day supply left. Severity: 2 Scope: 1 Complaint #NV00069580			