

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 02/12/2025	
NAME OF PROVIDER OR SUPPLIER OAKMONT OF LAS VEGAS				STREET ADDRESS, CITY, STATE, ZIP CODE 3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121			
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a Facility Reported Incident (FRI) investigation completed in your facility on 02/12/2025, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups The census at the time of the survey was 85. The sample size was one. There was one FRI investigated. Substantiated without deficient Practice: FRI 10236 was substantiated with no deficient practice. The investigation of FRI included: Observation of staff to resident interaction and a tour of the facility. Interviews were conducted with the Business Office Manager, and Executive Director Record Review of one record, which included the resident of concern. Document Review included facility policy and procedures, 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action necessary. Please retain a copy for your records.						

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.