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 _____	**05/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKEY ASSISTED LIVING	**3900 W OAKEY BLVD, LAS VEGAS, NEVADA ,89102**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 05/13/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 112 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and/or assisted living services, Category II residents. The census at the time of the survey was 74. Seventeen resident files and nine employee files were reviewed. The facility received a grade of C. There were three complaints investigated. Unsubstantiated: 1. Complaint #NV00073792 could not be substantiated. No regulatory deficiencies could be identified. 2. Complaint #NV0073965 was unsubstantiated due to a lack of evidence. No regulatory deficiencies could be identified. Substantiated: 3. Complaint #NV00074151 was substantiated. (See TAG 0967). The investigation of the complaints included: Observations of staff interacting with residents, medication administration and refill order process, memory care door alarms, resident rooms for those individuals prescribed the use of oxygen, and a tour of the facility. Interviews were conducted with the residents including a resident of concern, Caregivers, Medication Technicians, the Wellness Director and the Facility Consultant. Clinical Record Review of 17 records, which included the residents of concern. Document review included facility policy and procedures. 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	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: PHILIP PRENTISS Title: Administrator Date: 07/03/2025

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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	were identified:			
0255 SS= E	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 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 05/13/2025, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. The ice scoop was stored in the bin of the ice machine with the handle of the scoop directly touching the ice. b. Employee personal food was stored among resident food in the memory care refrigerator. c. The following non-food contact surfaces were soiled with grease and/or dust build-up: behind the equipment on the cook's line, the sides of the deep fat fryer and the underside of the shelf on the range. 2. Equipment and Maintenance Violations: a. The grease catch pan on the left side of the cook's line ventilation hood was not installed. b. A fan guard was not installed over the evaporator fan in the reach-in refrigerator on the right side of the kitchen. Severity: 2 Scope: 2	0255	1) We have corrected the specific findings by either policy signage changes, or cleaning log additions, or newly replaced items (see attachments). 2) We have put in place various changes to include a weekly cleaning log to better track who and when various cleanings have taken place. We did find the grease pan in a drawer as it was washed then mistakenly put it in a drawer. 3) We will monitor the other corrective actions by inspecting weekly the cleaning logs and the interior of the Memory Care refrigerators to make sure the policy changes as reflected in the new signage located on the front of the refrigerator, is being followed. All other deficiencies were corrected by replacing items that were no longer effective for use, ie; ice scoop and missing fan cover. 4) The Chef will be responsible for making sure the plan for all deficiencies noted are implemented correctly. 5) June 1, 2025 6) The following (picture) attachments are included: Signage changes, cleaning log sample, grease pan, ice scoop replacement, refrigerator fan guard replacement.	06/01/2025

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0770 SS= D	Residents Having Contractures - NAC 449.2724 Residents having contractures. (NRS 449.0302) 1. A person who has contractures must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless the contractures do not adversely affect the ability of the resident to perform normal bodily functions and: (a) The resident is able to care for the contractures without assistance; or (b) Supervision in caring for the contractures is provided by a medical professional who is trained to provide such supervision. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a waiver, to retain a resident with contractures, for 1 of 15 residents (Resident #3). Findings include: Resident #3 (R3) was admitted on 04/01/25 with diagnosis including dementia and bilateral hand contractures. On 05/13/25, in the morning, R3 was observed in the dining area, being assisted by a staff member, with feeding. Both of R3's hand had contractures. On 05/13/25, in the morning, a Medication Technician indicated R3 was fully dependent for all Activities of Daily Living due to both hands having contractures. Review of R3's medical record revealed there was no documented waiver to retain R3 in the facility. On 05/13/25, in the morning, the Wellness Director confirmed R3 had contractures of both hands and they had not obtained a waiver to retain R3 in the facility. Severity: 2 Scope: 1	0770	1) We have secured a new Home Health Agency for Resident #3 and are currently working with them on expediting a Plan of Care which we need to request a waiver that will replace the waiver request earlier submitted and rejected. 2) We have reinforced contractures as a need for an exemption request if the contracture interferes with any access to the body for conducting ADL's like feeding oneself. We have informed all staff who assess potential Residents to be aware of the regulations and to make sure any prospect with Contractures is noted on the Assessment form so that we can prepare an exemption request prior to admittance, if we are going to accept the Resident. 3) We will monitor the corrective action by making sure that when a resident is admitted, our ADL assessment we do upon arrival matches the assessment forms used to accept the Resident, and when they do not match, we will immediately apply for a waiver if the condition warrants. 4) The Care Director will be responsible for making sure the plan is implemented correctly. 5) July 6, 2025 6)Home Health Letter affirming a POC is in progress	07/06/2025
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - 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 , physician assistant or advanced practice registered nurse has	0878	1) We have corrected the specific finding by receiving a discontinuation order from the current PCP regarding the Acidophilus Medication (see exhibit B). It was evident upon further investigation that the list the Acidophilus Medication was on was an old list and was therefore entered into the system in error (see Exhibit A). The current PCP never had this medication for this	06/01/2025

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	approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. 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, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse 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 (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, physician assistant or advanced practice registered nurse 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, physician assistant or advanced practice registered nurse, a 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.		resident but upon our request discontinued it from our RES #3's medication record. 2) We have put in place changes so this error will not recur by making sure all Medication Technicians do not directly input new resident admittance medication records into the system without having the Care Director sign-off on the list, and by also making sure that the medications are at the facility. 3) We will monitor the corrective action by updating our medication cart reconciliations weekly instead of bi-weekly, and to reconcile new resident medications the same day after admittance to better catch entry errors. 4) The Care Director will be responsible for making sure the plan is implemented correctly. 5) June 1, 2025 6) The following attachments are included; (Exhibit A & B)	

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	Inspector Comments: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with Physican's orders, for 1 of 15 residents (Resident #3). Findings include: Resident #3 (R3) was admitted on 04/01/25 with diagnosis including dementia and bilateral hand contractures. Physicians orders for R3 dated 04/01/25, documented Acidophilus 1, take one capsule, by mouth, twice a day. Medication cart check for R3, revealed there was no Acidophilus 1 on the medication cart. Medication Administration Record for May 2025 revealed R3 had not received Acidophilus 1 since 05/07/25. On 05/13/25, in the morning, a Medication Technician confirmed R3 had not received Acidophilus 1 in accordance with the physician's orders since 05/07/25. Severity: 2 Scope: 1			
0967 SS= D	Alzheimer’s Care - NAC 449.2754 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (c) A description of: (1) The basic services provided for the needs of residents who suffer from dementia; (2) The activities developed for the residents by the members of the staff of the facility; (3) The manner in which behavior will be managed; (4) The manner in which medication for residents will be managed; (5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and (6) The steps the members of the staff of the facility will take to: (I) Prevent residents from wandering from the facility; and (II) Respond when a resident wanders from the facility; Inspector Comments: Based on	0967	1) We have corrected the specific finding by installing new louder alarms and adding locks on sliding glass doors and windows, if they were not already there, while adjusting the width for opening the sliding glass doors & windows that did have locks so that nobody can squeeze through. We have completed the installation of all Memory Care rooms so that elopement, if attempted, must go through the main exits. 2) We have put in place these safety changes so that it is more difficult to elope. We expect these enhancements to security for the Residents will be welcome by all. 3) We will monitor the corrective action by having the maintenance department to check alarms and door security on their regular monthly preventive maintenance room visits, and caregivers to check on a daily basis as well the alarms. 4) The Memory Care Director will be responsible for making sure the plan is implemented correctly. 5) June 1, 2025 6) The following attachments are included: The locking mechanism at bottom of sliding	06/01/2025

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	observation, document review, record review and interview the facility failed to ensure a patio door was alarmed to notify staff a resident had eloped from the facility. (Resident #15) Findings include: Resident #15 (R15) R15 was admitted to the facility on 04/19/25 with a diagnosis of Alzheimer's. A Facility Incident Report dated 04/22/2025 documented R15 eloped from the facility at 8:30 AM. R15 exited the facility through the sliding glass door in room 150 by jumping over the balcony when Maintance staff were updating the room. At the time of the incident the Medication Technician was in the resident of concern's room and heard a door alarm go off, left the resident's room to the answer door and by the time the Medication Technician went back to the resident's room the resident was gone. Medication Technician notified all staff. Resident was found five minutes later in the church parking lot and was returned to the facility. Medication Technician asked resident if resident was hurt, and resident was not. On 05/13/25 in the morning, the Wellness Director verbalized resident was looking for resident's dog and eloped through the sliding glass door by jumping over the balcony's brick wall to the church parking lot. The Wellness Director acknowledged the sliding glass doors were supposed to have locks on them but the sliding glass door the resident eloped out of, was not locked at the time nor had a door alarm that sounded to notify R15 has eloped from room 150. On 05/13/25, in the morning, the Wellness Director indicated the facility had a process to ensure all residents were accounted for when a door alarm to the memory care unit goes off, but since resident left through the sliding door that did not have an alarm, staff did not hear or see the elopement. Severity: 2 Scope: 1 Complaint #74151		doors and on windows, as well as picture of alarm in case the door should be opened.	

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview the facility failed to ensure sliding glass doors located in resident's rooms leading to the outside of the facility were properly secured. Findings include: On 05/13/25 in the morning, while touring the memory care unit the sliding glass doors located in room numbers 133, 134, 135, & 145 were able to open enough to potentially allow a resident to exit out the door, and there was no alarm or buzzer to alert staff to the door being opened if a resident had exited from the door. On 05/13/25 in the morning, the Maintenance Assistant acknowledged the sliding glass doors in rooms 133, 134, 135, & 145 could open far enough to potentially allow a resident to exit, and verified and there was no alarm or buzzer to alert staff to the door being opened if a resident had exited from the door. Severity: 2 Scope: 3	0991	1) We have corrected the specific finding by adjusting sliding glass door locks so the width is narrower so nobody can squeeze through. We have completed the installation of all sliding glass door locks and alarms in Memory Care rooms. 2) We have put in place these safety changes so that it is more difficult to elope. We expect these enhancements to security for the Residents will be welcome by all. 3) We will monitor the corrective action by having the maintenance department to check alarms and door security on their regular monthly preventive maintenance room visits, and caregivers to check on a daily basis as well the alarms. 4) The Memory Care Director will be responsible for making sure the plan is implemented correctly. 5) June 1, 2025 6) The following attachments are included: The locking mechanism at bottom of sliding doors and on windows, as well as picture of alarm in case the door should be opened.	06/01/2025
1825 SS= E	Designation/Training persons for IC Program - NAC 449.0109 Designation and training of person responsible for infection control. 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible	1825	1) We are corrected the specific finding by changing the Primary Infection training person from EE#1 to our Business Manager, (say EE#10). (see #10 added to identifier list attached). These training documents required for Primary and Secondary Infection Control Personnel are now in the Employee folders for EE#10 & EE#2 at Oakey Assisted Living. 2) We have put in place changes so that	07/02/2025

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	for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control staff completed 15 hours of infection control training annually (Employees #1 and #2). Employee #1 (E1): E1 was hired as the Administrator on 02/06/25. On 05/13/25 in the morning, E1 was identified as the current secondary infection control person for the facility. E1's file lacked documented evidence of 15 hours of infection control training regarding the control and prevention of infections from an approved organization within 3 months of being named the secondary infection control person. Employee #2 (E2): E2 was hired as the Wellness Director on 02/01/24. On 05/13/25 in the morning, E2 was identified as the current primary infection control person for the facility. E2's file contained		this error might not happen again by reinforcing with the new Human Resource Manager/Director of Operations, that employees at other facilities including some of our other properties may have needed documents in those facility files that might help complete a prospect for hire faster. 3) We will monitor the corrective action by indexing all Employee file documents so that this does not happen again. 4) The Director of Operations/HR Manager will be responsible for making sure the plan is implemented correctly. 5) July 2, 2025 6) The following attachments are included: EE#10 & EE#2 Infection Control Certificates & "new" numerical identifier list	

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	documentation of approved infection control training completed in December of 2023, and documentation of approved infection control training completed in November of 2024. E2's file lacked documented evidence of a total of 15 hours of annual infection control training regarding the control and prevention of infections from an approved organization. On 05/13/25 in the afternoon, E2 acknowledged E1 had not completed an initial 15 hours of approved infection control training, and E2 had not completed a total of 15 hours of annual approved infection control training. Severity: 2 Scope: 2			

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1840 SS= D	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 8 sampled employees obtained the required infection control training (Employee #3). Employee #3 (E3) E3 was hired on 12/08/23 as a Caregiver. E3's file contained a certificate dated 12/26/24 on the goal of infection control from an approved organization. E3's file lacked documented evidence of the required annual training on hand hygiene, the use of personal protective equipment, environmental cleaning and disinfection, a review of how pathogens spread, and the use of source control to prevent pathogens from spreading. On 05/13/25 in the afternoon, E2 acknowledged E3 had not completed the required infection control training for unlicensed caregivers. Severity: 2 Scope: 1	1840	1) We have corrected the specific finding by finding certificates EE#3 had at home and some recently completed. These required documents are now in the Employee folder as required. 2) We have put in place changes that require the HR Manager/Dir. of Operations to make sure the training completed matches the titles required for all Unlicensed Caregivers. A copy of the new Infection Control training topics has been given to the HR Manager. 3) We will monitor the corrective action by indexing all files to verify the certificates in the folders are matching the required topics that need to be covered. 4) The HR Manager/Dir. of Operations will be responsible for making sure the plan is implemented correctly. 5) June 1, 2025 6) The following attachments are included: 6 current infection control certificates for EE#3.	06/01/2025