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 _____	**09/09/2025**

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

(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 completed at your facility on 09/09/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 83. The sample size was six. The facility received a grade of A. There were seven complaints investigated. Substantiated without deficient practice: 1. Complaint #NV00074720 was substantiated with no deficient practice. 2. Complaint #NV00074744 was substantiated with no deficient practice. 3. Complaint #NV00074748 was substantiated with no deficient practice. Unsubstantiated: 4. Complaint #NV00074531 could not be substantiated. No regulatory deficiencies could be identified. 5. Complaint #NV00074788 could not be substantiated. No regulatory deficiencies could be identified. 6. Complaint #NV00074795 could not be substantiated. No regulatory deficiencies could be identified. 7. Complaint #NV00074804 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaints included: Observations of locked Memory Care unit, clean resident rooms, running water, staff assisting resident with Activities of Daily Living, call bell response time, temperature of resident rooms, cable television, toilet height, and care staff providing timely assistance to residents. Interviews were conducted with residents, Caregivers, Medication Technicians, a consultant, the Administrator and a Resident Care Coordinator. Record Review of records, which included the residents of concern. Document Review included facility policy and procedures, staffing schedule, fire drills, staffing schedule, Medication Administration Record, and incident reports. The findings and conclusions of any investigation by the Division of Public and	0000		

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

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 _____	**09/09/2025**

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

(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
	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 records.			