

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 01/08/2026
NAME OF PROVIDER OR SUPPLIER OAKEY ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 W OAKEY BLVD, LAS VEGAS, NEVADA ,89102	
(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 complaint investigation completed at your facility on 01/08/26, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 82. The sample size was five. The facility received a grade of A. There were two complaints investigated. Substantiated without deficient practice: 1. Complaint #NV00074820 was substantiated with no deficient practice. 2. Complaint #12373 was substantiated with no deficient practice. The investigation of the complaints included: Observations of lunch, laundry services, medication administration, and a tour of the facility. Interviews were conducted with residents, a Caregiver, Sous Chef, Chef, Marketing, Receptionist, Housekeeper, Director of Operations, Business Office Manager, Wellness Director, and the Administrator. Record Review of records, which included the residents of concern. Document Review included facility policy and procedures, menu, TV notifications, Medication Administration Record, billing invoices, hospice record, destruction log, resident agreement, 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 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.			

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.